A Report on Health Sciences Education Planning for California: 1980-1982

TABLE N-3

Fall Enrollment in Associate-Degree Nursing Programs,

California Four-Year Institutions

1972 - 1979

Institution	<u>1972</u>	1973	1974	<u>1975</u>	1976	<u>1977</u>	<u>1978</u>	1979
Loma Linda Mt St Mary's Pacific Union	94 39 <u>146</u>	114 94 <u>171</u>	148 91 <u>164</u>	169 96 <u>182</u>	167 124 <u>182</u>	85 139 164	79 137 168	59 - 133 <u>139</u>
Total	279	379	403	447	473	388	384	331

Enrollment in B.S.-degree nursing programs is shown in Table N-4 on the following page. Apparent variations from year to year in enrollment levels, particularly in the State University and Colleges, may actually reflect periodic difficulty in determining how certain students should be counted, a problem growing out of the way that various nursing and pre-nursing programs are organized.

There are also a number of programs which offer B.S. degrees for students who already are licensed as registered nurses. The rapidly growing enrollment in these programs is shown in Table N-5

Fall Enrollment in B.S. Nursing Programs California Four-Year Institutions, 1972-1979

1979	95 285	380	115	196	4 61	220	181	486 ×	713*	348	408	357	547	4,074	146	194	340	172	123	ı	622	1,597	
1978	97	378	102	227	394	212	198	515*	7 39*	366	385	363	452	3,953	96	198	311	135	122	1	599	1,461	
1977	98 293	381	103	236	434	163	189	571*	727*	354	400	411	457	4,045	7 9	180	372	129	263	1	403	1,411	
1976	123	410	83	232	473	176	182	577*	814*	346	419	338	944	4,086	76	353	254	124	259	ı	391	1,495	
1975	92 269	361	105	254	491	195	146	578*	784*	337	310	342	443	3,985	AN	141	255	120	111	1	363	ı	
1974	95 336	431	118	274	439	120	167	887	723*	313	279	325	442	3,688	96	178	279	118	67	. 1	365	1,036	
1973	88 319	408	168	667	302	302	197	456	979	967	£67	306	206	4,301	I	210	265	113	57		328	066	
1972	102	413	160	067	757	284	193	788	818	517	575	266	489	4,693		י ה	1/2	5 71	201	1 6	294	771	
Institution	UCLA UCSF	Total, UC		CSC, DakerBileiu	CSU, CHICO	COU, Flesho	Coo, mayers	Coll Ion Beach		cou, bus augeres	CSU, Dacramento	San Diego State U.		Total, CSUC	i	Azusa Pacific	Biola	Loma Linda	Mt. St. Mary's	Foint Loma	Stanford U. of San Francisco	Total, Private Institutions	

*These institutions also have degree-completion programs for R.N.s, the students of which are included in these totals.

HEGIS; Board of Registered Nursing; Direct Institution Response. Source: For public institutions: HEGIS; UC Statistical Summary; CSUC Statistical Reports For private institutions:

COMMISSION REPORT 81-2 JANUARY 1981

A REPORT ON HEALTH SCIENCES
EDUCATION PLANNING FOR CALIFORNIA: 1980 - 1982

CALIFORNIA POSTSECONDARY EDUCATION COMMISSION

Resolution 1-81

Approving A Report on Health Sciences Education Planning for California: 1980-82

- WHEREAS, Pursuant to Section 22712.5 of the Education Code the California Postsecondary Education Commission is required to prepare biennially a Health Sciences Education Plan, and
- WHEREAS, The Commission is further required in this process to take into account the <u>Health Manpower Plan</u> produced by the Office of Statewide Health Planning and Development, and
- WHEREAS, The Commission has prepared the required Plan for 1980-82 in accordance with statute and along the lines it has deemed most appropriate for this biennial period, and
- WHEREAS, The Policy Development Committee of the Commission has reviewed and approved the Plan in its present form; now, therefore, be it
- RESOLVED, That the California Postsecondary Education Commission adopts the document entitled, A Report on Health Sciences Education Planning for California: 1980-82, and directs that it be published by the Commission and transmitted to the Governor, the Legislature, the Department of Finance, the Office of the Legislative Analyst, the segments of higher education, and other appropriate agencies and entities.

Adopted January 19, 1981

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INTRODUCTION

This is the second in a series of biennial health sciences education reports prepared by the Commission in response to Section 22712 5 of the Education Code. The reports are to contain, as a minimum, the following:

- a. a finding, taking into account, the <u>Health Manpower Plan</u>, as to the adequacy of enrollment levels to meet the needs for various types of health personnel;
- b. a finding as to the extent to which available clinical and classroom resources are utilized; and
- c. any recommendations on program changes which grow out of these findings.

This report contains three major sections. The first section assesses the adequacy of educational programs in meeting the needs of California for professional personnel in medicine, nursing, dentistry, pharmacy, and optometry. Data on enrollments and graduation rates in these fields are updated from the 1978 Plan, and similar data on the fields of osteopathy and podiatry are included for the first time. Progress in implementing recommendations from the 1978 Plan is assessed. In addition, the role of nurse practitioners in geriatric health care is examined as the final portion of a report made to the Legislature earlier in 1980 on potential educational needs in geriatric medicine.

The first section of this report also reviews the most recent Health Manpower Plan-the companion document produced by the Office of Statewide Health Planning and Development-which the Commission is mandated to "take into account" in developing the Health Sciences Education Plan. The State Health Plan is also reviewed, particularly for its broad philosophical orientation

The second section of this report identifies the various careers which are included in the generic term of allied health. After establishing a classification structure for allied health, the report describes the educational and training programs in these fields with respect to institutional setting, enrollments, and numbers of graduates.

The final section of the report briefly reviews preventive health care, and the educational components which provide the professional personnel for prevention vis-a-vis cure in health care

In departing somewhat from the format used in the 1978 Health Sciences Education Plan and that of the earlier 1976 Plan produced by an outside contractor, the Commission does not wish to suggest a shift of emphasis from the primary concerns discussed in those earlier reports. However, since certain of those issues have already been thoroughly analyzed and discussed, it was felt that the 1980 report might more profitably explore some new ground rather than limit itself to the issues considered in the past.

Such a decision in no way diminishes the Commission's established commitment to work toward the resolution of important problems in health sciences education. The inclusion here of a progress report on the issues identified in the 1978 Plan is evidence of the Commission's ongoing concern over these issues. Beyond that expression of concern the Commission wishes to take one additional step: the emphatic reaffirmation of the strength of its commitment to the recommendations made in 1978, particularly those dealing with the need to insure that underrepresented minorities and women are brought into professional education programs in the health sciences in significantly larger numbers.

This document was developed in the context of a series of other related reports which collectively describe the State's overall purposes in the postsecondary education programs it supports, including those in the health sciences. To be specific, the particular goals and strategies of health sciences education programs can best be identified from the academic plans of the several segments and institutions. Similarly, the goals and strategies whereby segments and institutions are seeking to increase enrollment of underrepresented minorities and women are to be found in the affirmative action plans of segments and institutions, particularly those dealing with graduate and professional education. The goals of specific educational programs are often described in the catalogs and other basic institutional statements; such goals are sometimes more implicit than explicit, as faculty members share an unspoken commitment to quality, rigor, and individual challenge in the educational process. Finally, the overall goals of postsecondary education in California--in terms of personal and societal needs, tempered by the constraints under which such education operates--are examined in the Commission's Five-Year Plan for Postsecondary Education.

PART I

GENERAL UPDATE

SECTION A: AN UPDATE OF INFORMATION IN THE 1978 HEALTH SCIENCES EDUCATION PLAN

The Commission's 1978 Health Sciences Education Plan provided data on enrollments and graduation rates in professional education programs in five fields: medicine, nursing, dentistry, pharmacy, and optometry. It also contained information on the composition of student bodies and graduating classes in the health sciences by sex and ethnicity

The 1978 Plan explored a number of the issues surrounding the training and utilization of these health professionals. This second report does not review these issues to the same degree. Instead, it concentrates on updating the enrollment/output data on the educational programs in the five health professions previously reviewed, and on providing similar data on educational programs in other health occupations.

The tables that follow display the most recent data on enrollments and graduation rates-enrollments for the fall of 1979, graduation rates for the 1978-79 academic year. Interpretative comments are offered as appropriate.

Medicine

Enrollments in the eight medical schools in California are depicted in Table M-1.

TABLE M-1
Fall Enrollment in Medicine, California Institutions
1976 - 1979

M . 48 7									
Medical School		1972	1973	1974	<u> 1975</u>	<u>1976</u>	1977	1978	1979
UCD		293	347	401	408	405	402	406	402
UCI		258	246	257	301	308	293	312	367
UCLA		550	557	604	617	598	582	595	609
UCR		-		-	-	-	16	35	46
UCSD		211	233	275	319	350	384	425	467
UCSF		555	<u> 565</u>	575	633	<u>590</u>	613	626	616
	tal blic	1,867	1,948	2,112	2,278	2,251	2,290	2,399	2,507

TABLE M-1 (Continued)

Lome Linds Stanford USC	45 6 334 445	599 370 <u>439</u>	627 374 472	640 396 517	572 352 541	588 362 <u>571</u>	642 340 <u>587</u>	619 3 8 0 549
Total Private	1,235	1,408	1,473	1,553	1,465	1,521	1,569	1,548
GRAND TOTAL	3,192	3,356	3,585	3,831	3,716	3,811	3,968	4,055

Sources UC Statistical Summary; WEGIS, UC Office of Health Affairs

For the first time, overall enrollment in California medical schools has exceeded four thousand students. It is apparent that this continued growth during the past four years is due to increased admissions at the University of California, not the private sector Articles in the popular press may suggest that a lid has been placed on enrollment in medical schools—thus limiting educational opportunity—but the fact remains that enrollment in the University's medical schools has grown by more than a third (34.5%) in the last seven years. Additional growth may yet occur, particularly at the Los Angeles campus, which will be operating a third— and fourth—year clinical program at Charles R. Drew Postgraduate Medical School for forty—eight students, but enrollments should stabilize early in the 1980s as capacity is reached.

The composition of medical school enrollment, by sex and ethnicity, is shown in Table M-2.

Several interesting trends can be noted from Table M-2. First, overall enrollment in both public and private medical schools in California continues to rise; however, this increase does not apply equally to the various "minority" groups. In the University of California, the percentage of Black enrollment has dropped in three years from 6.3 to 5.2, primarily as a result of a nearly 30 percent decline in the enrollment of Black males. For Chicanos, the percentage of enrollment has dropped from 9.5 to 9.2, also reflecting declining male enrollment. However, the total number of Chicanos has increased somewhat (from 213 to 231), while there has been a net loss of Blacks (from 141 to 130).

In the private medical schools, conflicting trends are discernible. Black enrollment has declined as a percentage of total enrollment-from 5.2 to 3.9--with a net numerical reduction as well (from 76 to 60). For Chicanos the percentage of enrollment has gone up from 4 7 to 5.4, with a corresponding net gain in the number enrolled (from 69 to 84).

TABLE M-2

	979	N N	402 402 403	308 293 312 367	598 582 595 609	16 35 46	350 384 425 467	590 613 626 616	2,251 2,290 2,399 2,507
	1976-1979	<u>a</u>	128 133 135 142	60 63 65 101	119 133 151 169	4 80 80	62 82 85 111	202 213 227 227	571 628 671 744
		Total	277 269 271 260	248 230 247 266	077 777 677 677	12 27 38	288 302 340 356	388 400 399 403	1,680 1,662 1,728 1,763
	tutio	White Non- Hispanic	104 101 103 105	40 36 52	98 102 106 114	O N 4	48 67 86	148 154 158 153	438 461 475 524
	Institutions,	₹ <u>~</u> ;;[►	190 190 201 196	163 153 166 167	362 332 333 338	12 22 29	234 245 279 186	244 248 260 266	1,193 1,160 1,261 1,282
	rnia	Hispanic M	4 W 4 W	11 7	8 11 14 18	004	ላለላላ	19 20 20 20	4 5 4 9 6 9 9 9
	California	죈	21 13 15 15	35 41 46	46 34 34	000	12 15 17	53 8 8 8 53 3 8 8	173 172 157 165
		Fig.	16 15 19	3 10	5 7 11 13	11 1977 4 3 2	6 0 2 2 2	14 19 23	47 56 68 77
ABLE M-C	Ethnicıty,	Asian/ Pacific Islander	39 31 28	14 8 8 34	43 67 67	operational until 0 0 4 0 5 3 0 9 2	32 38 38	53 65 58	181 175 190 214
HP	and Etl	ican We Ye	0000	1101	0000	peratic 0 0 0	7777	0100	4446
	Sex a	American Indian/ Alaskan Native	2624	we02	m N O O	Not 0 0	1075	m004	15 10 4
	e, by	Black Non÷ Hispanic M	4878	9 11 17 11	6 11 14 19	000	8888	20 19 23 18	41 51 63
	Medicine,	Black Non- H19Den	20 16 14	21 19 22 17	20 20 20 20	000	L 8 4 L	35 75 70 70 70	100 92 82 71
	in Me	Non- Resident Allen M F	04 v v	0000	0.6620	0 0 1	0000	1044	3 15 15
		Residen Allen	5 11 10 13	10 15 0	2471	000	7662	он н н	23 K 23 K
	Enrollment								
	Fall E		UCD 1976 1977 1978 1979	UCI 1976 1977 1978 1979	UCLA 1976 1977 1978 1979	UCR 1976 1977 1978 1979	UCSD 1976 1977 1978 1978	UCSF 1976 1977 1978 1979	UC TOTAL 1 1976 1977 1978 1978

TABLE M-2 (Continued)

<u>A11</u>	572 588 642 619	352 362 340 380	541 571 587 549	1,465 1,521 1,569 1,548	3,716 3,811 3,968 4,055
Total	117 120 140 129	102 112 103 122	105 110 107 94	324 342 350 345	895 970 1,021 1,089
<u> </u>	455 468 502 490	250 237 238	436 461 480 455	1,141 1,179 1,219 1,203	2,821 2,841 2,947 2,966
White Non- ispanic M	101 95 109 107	71 77 65 81	93 79 69	265 257 253 257	703 718 728 781
₹ Ž	381 378 402 392	183 180 174 184	361 370 383 365	925 928 959 941	2,118 2,108 2,220 2,223
Hspanic M	2214	e 51 e 51	041216	11 16 15 19	51 66 64 85
H S	9446	21 20 24 24	31 38 33 33	58 65 65 65	231 241 230 230
Asian/ Pacific Islander	6 13 8	<u></u> ≻ ∞	601 111 13	2222	69 81 101 106
Asi Isla M	23.23	e 21 21 71	31 39 53	64 91 91	242 239 281 305
an/ an/ kan		4461	0770	26.45	11 8 5
American Indian/ Alaskan Native	7000	တစ္တက	0440	v0 ∞0 r~ v0	21 18 11 15
Black Non- Hispanic	401-4	8 11 14 14	3 00 6	15 24 31 24	56 75 83
E Z Z	24 17 13	27 26 15 19	10 17 17 4	61 60 46 36	161 152 128 107
Non- is ident	10 8 8	m n n n	3010	6 112 14	9 26 29
A A E	39 39 39 86	ស≀≀ ► ∞	ოდიი	30 50 51 64	84 88 88 88 88 88 88 88 88 88 88 88 88 8
	LOMA LINDA 1976 1977 1978 1979	STANFORD 1976 1977 1978 1979	USC 1976 1977 1978 1978	PRIVATE TOTAL 1976 1977 1978 1979	GRAND TOTAL 1976 1977 1978 1979

In both educational sectors, enrollment of women continues to climb, numerically as well as proportionately. In the University's five medical schools, the percentage of women enrolled has increased from 25.4 to 29.7, and in the private sector from 22.1 to 22.3. Numerically, enrollment of women has gone from 571 to 744 in the UC medical schools, and from 324 to 345 in the private medical schools.

Changes in the number of degrees awarded by California medical schools correspond roughly to changes in enrollment, although overall growth in degrees awarded far exceeds that in enrollment for this period, 41.5 percent to 34.5 percent. Again, it is clear that the sustained growth in recent years has occurred in the University of California, not the private sector. Table M-3 traces the pattern of medical school output in California.

The mix of these graduates, by sex and ethnicity, is displayed in Table M-4.

The continuing increase in the number of women graduating from medical school is immediately apparent. In three years, the percentage of women graduates has risen from 21.9 percent to 26.2 percent in the University's medical schools, and from 17.0 percent to 22.5 percent in the private schools. Numerically the totals have gone from 121 to 150 in the University, and from 58 to 82 in the private schools.

This increase is also apparent in the graduating rates for minorities. In three years, the percentage of Black students graduating from the University's medical schools has gone from 4.3 to 6.1; in the private schools, the percentage has gone from 2 6 to 6.6. The number of Black students graduating from UC medical schools has gone from 24 to 35; in private medical schools the number has gone from 9 to 24. For Chicanos, the percentage of graduates has risen from 4.7 to 7.5 in the University, and from 3.8 percent to 6.3 percent in the private schools. The number of Chicanos graduating from UC medical schools has gone from 26 to 43, and from private medical schools from 13 to 23.

TABLE M-3

Professional Degrees Conferred in Medicine, California Institutions, 1966-1979

	1978- 1979	153 161 95 77 87	573	153 81 131	365	938
	1977- 1978	148 152 89 76 88	554	136 94 143	373	927
	1976-	139 158 101 82 59	539	134 107 151	392	931
	1975-	156 158 99 74 65	252	113 72 157	342	894
	1974-	137 144 95 64 48	887	97 81 83	261	671
	1973-	136 132 50 63 52	433	103 74 133	310	743
	1972-	133 136 49 67 50	435	88 88 220	393	878
MIC YEAR	1971-	122 130 46 64 455	407	84 75 97	256	699
ACADEMIC	1970-	131 113 - 64	308	74 69 95	238	975
	1969- 1970	126 78 - 58	797	73 69 85	227	687
	1968- 1969	130 71 - 75	7.6	69 61 69	661	475
	1967-	128 76 - 89	293	67 61	211	504
	1966-	101 68 - 87	256	71 48 88	207	463
	1965- 1966	99 70 888	257	63 54 89	907	463
_	Medical	UCSF UCLA UCD UCI UCSD	Total Public	USC Stanford Loma Linda	Total Private	GRAND TOTAL

*First graduating class

John C. Wong, Health Manpower Study of Selected Health Professions in California, 1976, and the Higher Education General Information Survey Sources

TABLE M-4
Professional Degrees Conferred in Medicine, by Sex and Ethnicity
California Institutions, 1976-1979

		dent en F	1	lack lon- panic F	Ind Ala	rican ian/ skan tive F	Pac	nan/ ific ander F	<u>H15</u>	panic F	I	hite Non- spanic F	 M	otal F	<u> </u>
UCD															
1975-1976	0	1	2	3	0	1	8	2	2	3	54	23	66	33	9 9
1976-1977 1977-1978	2	0	5	1	0	0	18	2	5	0	51	17	81	20	101
1978-1979	0 1	0	2	1 0	1 1	0	8	1	6	0	46	24	63	26	89
1370 1377	_	U	J	U	ī	0	7	5	2	2	52	22	66	29	95
UCI															
1975-1976	2	2	0	0	0	0	5	0	1	0	52	12	60	14	74
1976-1977	2	0	3	0	1	0	7	1	4	0	51	14	67	15	82
1977-1978 1 978- 1979	1 1	0	7 6	2	l	1	4	0	3	2	45	11	61	16	76
1370 1373	1	U	Б	4	0	0	2	1	10	Q	45	8	64	13	7 7
UCLA															
197 5- 1976	2	2	2	1	0	0	13	0	6	2	114	16	137	21	158
1976-1977	0	1	6	2	1	0	16	2	5	1	104	20	132	26	158
1977-1978	1	0	5	2	2	0	11	1	15	2	95	18	129	23	152
1 978- 1979	1	1	3	1	0	0	13	3	10	1	96	32	123	38	161
UCSD															
1 975- 1976	0	1	3	2	1	0	3	0	5	1	36	13	48	17	45
1976- 1977	2	1	0	0	ō	ō	6	ì	2	1	42	4	52	7	65 59
1977-1978	0	0	3	0	0	0	3	ī	2	ō	59	20	67	21	88
1 978- 1979	1	0	2	1	0	1	10	3	2	2	57	10	72	15	87
UCSF															
1975-1976	1	0	8	3	0	0	15	4	5	1	0.1	20	100	26	156
1976-1977	0	1	12	2	ĭ	ō	7	ī	6	4	91 75	28 30	120 101	36 38	156 139
1977-1978	0	0	7	2	0	0	14	ī	6	4	70	44	97	51	148
1 978-197 9	0	ð	10	5	0	0	17	6	14	2	57	42	98	55	153
UC TOTAL															
1975-1976	5	6	15	9	1	1	44	6	10	-	2/7				
1 976- 1977	6	3	26	5	3	ō	54	7	19 22	7 6	347 323	92 85	431 433	121	552
1 977- 1978	2	0	24	7	4	ī	40	4	32	8	315	117	433 417	137 137	570 554
1 978- 197 9	4	1	24	11	1	1	49	18	38	5	307	114	423	150	573
LOMA LINDA															
1975-1976	13	1	3	0	1	0	7	٥	2	,	110				
1976-1977	8	2	4	ĭ	í	o	7	2	3 2	1 0	110 109	18 15	137	20	157
1977-1978	7	2	8	ō	ī	õ	2	ĩ	ĩ	ĺ	98	22	131 117	20 26	151 143
1 978- 1979	2	1	6	2	0	0	9	4	ĺ	ō	83	23	101	30	131
STANFORD															
1975-1976	o	0	2	0	0	0	0	0	4						
1 976- 1977	2	0	3	2	1	ő	2	3	9	0 1	50 63	16 21	56 80	16	72
1977-1978	2	0	10	0	ī	ī	4	õ	6	3	46	21	69	27 25	107 94
1978-1979	1	1	3	3	0	0	1	3	3	ĭ	45	20	53	28	81
usc															
1975-1976	0	0	4	o	0	0	_	•	-	•					
1976-1977	Ö	ŏ	2	Ö	0	o	5 5	3 1	5 7	0 1	77 94	19	91	22	113
1977- 1978	1	1	ī	2	ì	ŏ	4	1	7	1	94	24 25	108 10 6	26 30	134 136
1 978- 1979	0	0	6	4	1	l	11	2	17	1	94	16	129	24	153
PRIVATE TOTAL													-		
1975-1976	13	1	9	0	,	•	10			_					
1 976- 1977	10	2	9	3	1 2	0 0	12 14	3 6	12 18	1 2	237	53	284	58	342
1 977- 1978	10	3	L9	2	3	1	10	2	14	5	266 236	60 68	319 292	73 81	392
1 978- 1979	3	2	15	9	ì	î	21	9	21	2	222	59	283	81 82	373 365
GRAND TOTAL														- -	
1975-19 76	18	7	24	n	•			~		_			_		
1976-1977	16	5	35	9 8	2 5	1 0	56 68	9 13	31	8	584	145	715	179	894
1977-1978	12	3	43	9	7	2	50	13 6	40 46	8 13	589 551	145	752	210	962
1978-1979	7	3	39	20	2	2	70	27	59	7	529	185 173	709 70 6	218 232	927 938
- · · · · · · · · · · · · · · · · · · ·											 2	-,-	, 50		7.34

Nursing

Information on enrollments and graduation rates in nursing is contained in the following series of tables, which reflect the various levels and types of training programs for registered nurses.

Enrollments in nursing continue to rise in most sectors of California education, contrary to trends reported nationally. Table N-1 shows enrollments in the four remaining diploma nursing programs.

TABLE N-1
Fall Enrollments in Hospital Nursing Programs, 1972-1979

Institution	1972	<u>1973</u>	1974	<u>1975</u>	<u>1976</u>	<u>1977</u>	1978	1979
CONTINUING PROGRAMS								
St. Luke's	126	133	139	137	132	126	136	141
CA Hospital Medical Ctr	143	143	151	151	166	166	140	108
L A County Medical Ctr	453	479	405	375	260	324	365	383
Samuel Merritt	186	208	205	216	277	160	189	196
Total	908	913	900	879	835	776	830	828
DISCONTINUED PROGRAMS								
Kaiser	184	162	112	57	_	_	_	-
San Jose Hospital	164	80	39	-	_	_	-	-
St Vincent's	81	82	-	-	_	-	-	-
Hollywood Presbyterian	142	-	-	-	-	-	-	-
Queen of Angels	49	_	_	_	-	-	_	-
St Joseph's	29							
Total	649	324	151	57	-	-	-	-
TOTAL, ALL PROGRAMS	1,557	1,237	1,05Î	936	835	776	830	828

Sources Mursine Board, Individual Hospitals

Associate-degree nursing programs in the Community Colleges are the largest single source of nursing graduates in California. Enrollments in these programs continue to increase, as shown in Table N-2.

There are also three associate-degree nursing programs offered by four-year institutions. Enrollment in these programs, according to Table N-3, seems to have peaked and now is declining.

TABLE N-2
Fall Enrollment in Associate-Degree Nursing Programs
California Community Colleges, 1972-1979

<u>School</u>	1972	<u> 1973</u>	1974	1975	<u> 1976</u>	1977	1978	1979
American River	74	68	73	68	67	75	76	69
Antelope Valley	86	69	68	72	79	77	82	91
Bakersfield	70	86	91	84	72	92	114	125
Cabrillo	66	66	36	72	74	72	75	77
Cerritos	126	132	152	175	172	147	157	167
Chabot	90	92	64	99	90	87	89	90
Chaffey	9 9	105	76	110	144	148	142	138
C C of San Francisco	145	145	147	172	175	186	174	180
College of the Desert	100	115	126	135	143	145	146	140
College of Marin	9 9	103	98	106	103	103	93	108
College of the Redwoods	54	55	65	63	65	66	66	66
College of San Mateo	143	119	121	127	121	105	115	120
College of the Sequoias	67	65	65	65	65	77	82	86
Compton College	115	121	136	135	132	124	116	120
Contra Costa	166	159	166	161	171	145	128	121
Cuesta	52	50	50	52	51	53	53	65
Cypress	153	169	165	168	172	15 1	141	149
De Anza	121	116	100	108	107	111	105	107
East Los Angeles	124	137	185	194	184	196	180	167
El Camino	118	138	155	153	152	152	170	224
Fresno City College	113	117	113	116	143	137	144	118
Golden West	150	153	179	196	220	208	213	256
Grossmont	88	102	101	100	107	105	105	103
Hartnell	58	58	65	62	62	61	56	62
Imperial Valley	69	64	67	12	71	88	78	72
Long Beach City College	197	198	221	245	257	239	256	259
L A City College	233	259	240	200	174	175	150	148
L A Harbor College	156	169	161	167	166	168	160	174
L A Pierce	110	145	162	166	173	173	169	169
L A Southwest	125	163	131	193	118	206	209	150
L A Trade-Technical	67	66	64	311	311	102	209 99	93
L A Valley	232	247	275	306	268	295	289	269
Los Medanos	232	247	20	38	65	293 41	44	47
Merritt College	93	96	95	99	105	105		
Modesto J C	129	174	161	134	185	137	107 176	108
Mt San Antonio	100	109	103	115	101	110		180
Vapa	94	110	112	96	95	89	129 9 7	130
Ohlone	40	85	80	76	93 81	39 77	70	93 77
Palomar	89	107	99	117	119	132	147	146
Pasadena City College	180	252	264	243	255	218	236	240
Rio Hondo	110	126	142	148	173	175	181	200
Riverside City College	175	185	185	191	201	197	184	169
Sacramento City College	116	115	118	132	133	129	121	126
Saddleback	82	- 107	- 127	103	124	194	151	188
San Bernardino Valley	98	103	116	110	116	117	122	118
San Diego City	27	30	29	30	33	32	39	43
San Joaquin Delta	110	113	123	127	125	133	129	124
San Jose C C -					120	100	127	12-4
Evergreen Valley	134	134	135	147	164	143	159	156
Santa Ana		30	30	30	55	59	47	47
Santa Barbara C C	78	83	83	91	74	82	102	97
Santa Monica C C	96	106	112	115	115	122	121	134
Santa Rosa C C	83	84	96	104	99	97	99	107
Shasta	59	66	69	66	73	70	74	72
Sierra	•	-	-	-	,,,	-	19	-
Solano	87	78	91	48	87	81	83	88
Southwestern	73	77	79	77	77	79	74	76
Ventura	99	98	9 5	123	120	131	165	200
Victor Valley				33	58	70	72	83
•								
Totals	5,820	6,319	6,482	7,098	7,242	7,089	7,180	7,332

Source Nursing Board

TABLE N-3

Fall Enrollment in Associate-Degree Nursing Programs,
California Four-Year Institutions
1972 - 1979

Institution	<u>1972</u>	1973	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
Lome Linds Ht St Hary's Pacific Union	94 39 <u>146</u>	114 94 <u>171</u>	148 91 <u>164</u>	169 96 182	167 124 182	85 139 <u>164</u>	79 137 == 168 =	59 133 <u>139</u>
Total	279	379	403	447	473	388	384	331

Enrollment in B.S.-degree nursing programs is shown in Table N-4 on the following page. Apparent variations from year to year in enrollment levels, particularly in the State University and Colleges, may actually reflect periodic difficulty in determining how certain students should be counted, a problem growing out of the way that various nursing and pre-nursing programs are organized.

There are also a number of programs which offer B.S. degrees for students who already are licensed as registered nurses. The rapidly growing enrollment in these programs is shown in Table N-5.

Fall Enrollment in B.S. Nursing Programs California Four-Year Institutions, 1972-1979

1979	95 285	380	196 491 220 181 498* 713* 408 357	4,074	146 194 340 172 123 622
1978	281	378	227 227 212 212 515* 739* 365 365	3,953	96 198 311 135 122 - 599
1977	98 293	381	236 434 163 189 571* 727* 400 411	43/	64 180 372 129 263 403
1976	123 287	410	232 473 176 182 577* 814* 419 338	446	94 353 254 124 259 - 391
1975	92 269	361	254 491 195 146 578* 337 342	3,985	NA 141 255 120 111 -
1974	95 336	187	274 439 120 167 488 723* 313 325	3,688	29 178 279 118 67 - 365
1973	88 319	805	499 302 302 197 456 496 423 306	4,301	210 265 112 57 18 328
1972	102	413	490 437 284 193 488 818 517 543	489	172 114 100 52 39 294
Institution	UCLA UCSF	Total, UC	CSU, Chico CSU, Fresno CSU, Hayward Humboldt State U. CSU, Long Beach CSU, Los Angeles CSU, Sacramento San Diego State U. San Francisco State U.	San Jose State U. Total, CSUC	Azusa Pacific Biola Loma Linda Mt. St. Mary's Point Loma Stanford U. of San Francisco Total, Private Institutions

in these totals.

HEGIS; UC Statistical Summary; CSUC Statistical Reports HEGIS; Board of Registered Nursing; Direct Institution Response. For private institutions: Source: For public institutions

TABLE N-5

Fall Enrollment in B.S. Programs for Previously Licensed Nurses, California Four-Year Institutions 1973 - 1979

Institution	1973	<u>1974</u>	1975	<u>1976</u>	<u>1977</u>	<u>1978</u>	1979
CSU, Fullerton CSC, San Bernardino	- -	36 120	141 106	237 110	288 101	271 119	255 99
Sonoma State U CSC, Stanislaus	119 	165	195	210	227 57	226 100	244 133
Total, CSUC	119	321	442	557	673	716	731
Holy Names Univ of San Diego California Lutheran	- 79 	18 90 	44 105	61 110	66 119	65 120 18	76 100 28
Total, Priv Inst	79	108	149	161	185	203	204

Sources HEGIS, Supplemented by data from CSUC Chancellor's Office

The composition of nursing enrollment by sex and ethnicity is available only for State University programs. Table N-6 displays these data in seven ethnic categories.

It is interesting to observe that during the three-year period covered by this table, Black enrollment in State-supported nursing programs declined from 7.4 percent of the total to 5.2 percent, while Chicano enrollment increased from 4.6 percent of the total to 6.0 percent. Male enrollment declined from 6.8 percent to 6.4 percent.

Information on nursing graduates is a better measure of what is happening quantitatively in nursing education than is enrollment because of the difficulty in determining who should be counted as a nursing major. Data on the number of graduates in various programs follow.

Table N-7 contains information on the number of graduates in diploma nursing programs

Graduation rates in associate-degree programs in the California Community Colleges are displayed in Table N-8.

TABLE N-6

Fall Enrollment in Nursing, by Sex and Ethnicity California Public Four-Year Institutions, 1976-1979

Altersfield 1	1		Mon-Resident Alien M	Black Non- Hispanic M F	Amer Ind / Alaska Nat M F	Astan/Pac Islander M F	Hispanic M F	White Non- Hispanic	Non- n1c	Filipino	No Resp	Other M		Total M F	Total, All
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TABLE N-7 Diplomas Conferred in Hospital Nursing Programs, 1972-1979

1978-79	32	162 51	288		788	
1977-78	39	126 50	255		255	
1976-77	41	120	275		275	
1975-76	40	229	371		371	
1974-75	45	163	318		56	
1973-74	34	175	304		45 35 - - - - - - - - - - - - - - - - - -	
1972-73	34	177	282		45 42 54 - - - 151 433	
1971-72	37	162	280		46 30 36 39 38 22 211 491	
Institution CONTINUING PROGRAMS	St. Luke's CA Hospital Medical Ctr.	L.A. County Medical Ctr. Samuel Merritt	Total	DISCONTINUED PROGRAMS	Kaiser San Jose Hospital St. Vincent's Hollywood Presbyterian Queen of Angels St. Joseph's Total Total	

Sources: Nursing Board; Individual Hospitals.

TABLE N-8

Degrees Conferred in Associate-Degree Nursing Programs
California Community Colleges, 1972-1979

School	1971- 1972	1972- 1973	1973- 1974	1974- 1975	1975- 1976	1 976- 1 977	1977- 1978	1978 - 1979
American River	26	37	33	33	35	28	35	39
Antelope Valley	36	34	35	28	31	40	33	32
Bakerafield	33	42	3 8	47	58	42	32	59
Cabrillo	35	25	24	36	33	35	34	36
Cerritos	42	53	49	71	78	84	71	86
Chabot	38	48	46	40	50	49	44	47
Chaffey	43	52	50	50	29	72	69	65
C C of San Francisco	51	42	69	87	81	80	88	85
College of the Desert	46	40	34	51	65	58	90	80
College of Marin	44	40	40	33	51	47	42	47
College of the Redwoods College of San Mateo	14	23	22	28	30	28	42	37
College of the Sequolas	41	40	50	35	45	49	37	5 2
Compton College	39 32	29	27	32	30	29	29	42
Contra Costa	96	52 85	51 75	63	46	46	42	42
Cuesta	25	26	75 26	79	70	74	64	59
Cypress	62	67	77	22 77	25 78	25	26	27
De Anza	47	56	54	55	33	76 45	85 27	69
East Los Angeles	48	49	66	64	92	45 45	34	45
El Camino	69	51	60	71	92 84	43 77	79 75	65
Fre smo City College	45	49	43	49	54	72	75 70	73 75
Goldem West	57	69	64	84	93	108	84	73 89
Grossmont	42	40	40	47	46	50	49	44
Hart ne ll	25	22	23	26	24	27	25	21
I mperia l Valley	-	30	26	23	32	24	24	34
Long Beach City College	72	89	82	102	119	129	115	128
L A City College	79	81	110	75	95	95	68	68
L A Harbor College	40	61	77	51	67	60	68	57
L A Pierce	50	30	60	74	71	75	81	74
L A Southwest	51	41	47	56	53	82	o 4	55
L A Trade-Technical	72	67	64	64	62	84	92	69
L A Valley	90	108	110	130	158	138	160	169
Los Medanos	-		-	-	16	20	19	20
Merritt College Modesto J C	52	43	49	46	49	50	52	55
Mt San Autonio	32	43	57	42	38	105	51	69
Napa	25 31	35	42	43	41	48	46	47
Ohlone	21	29	46	50	47	33	39	38
Palomer	27	— - -	- 32 61	- - 37		39	36	26
Pasadena City College	78	83	101	37 154	65	49	56	71
Rio Hondo	46	50	47	65	1 26 64	121	99	90
Riverside City College	54	61	71	71	81	84 93	82	84
Secramento City College	44	46	41	44	55	93 55	88 63	87
Saddleback	-	36	38	63	67	54	83	52
San Bernardino Valley	41	45	45	49	51	57	57	83 59
San Diego City	31	27	29	28	30	28	29	38
San Joaquin Delta	60	48	49	57	67	60	61	66
San Jose C C -								
Evergreen Valley Santa Ana	58	54	51	54	50	63	48	59
Santa Barbara C C	-	-	29	30	54	53	58	47
Santa Monica C C	24	32	37	36	14	37	22	28
Santa Rosa C C	36	42	54	59	60	65	57	62
Shasta	21 23	25	36	44	52	48	44	39
Solano	2 <i>3</i> 34	23 39	29	33	31	35	29	36
Southwestern	32	29	29 32	36	37	36	34	34
Ventura	51	42	52 52	33 39	33	37	33	34
Victor Valley	-	7 2			53	49	64	64
•					_	28	28	31
Totals	2,290	2,451	2,729	2,933	3,129	3,320	3,482	3,289

Source Nursing Board

Table N-8 reflects the first drop in recent years in the number of nursing degrees conferred by the Community Colleges. In the past, the continued growth in the number of graduates made it possible to resist pressures for additional programs which some people felt were needed to meet a perceived shortage of nurses. This decline should be monitored closely to determine if it is a harbinger of a new trend.

Some four-year institutions also offer associate-degree programs in nursing. Table N-9 displays data for these programs.

TABLE N-9

Degrees Conferred in Associate-Degree Nursing Programs,
California Four-Year Institutions
1972 - 1979

Institution	1972	1973	1974	<u> 1975</u>	<u>1976</u>	<u> 1977</u>	<u> 1978</u>	1979
Loma Linda	24	24	40	54	64	61	85	11
Mt St Mary's	-	-	34	36	32	46	69	66
Pacific Union	72	78	<u>t8</u> _	103	119	107	_99	102
Total, 4-year Institutions	96	102	157	193	215	214	253	179

Source Nursing Board

The total number of students receiving the B.S. degree in nursing continues to rise in both public and private institutions. These increases can be seen in Table N-10 on the following page.

TABLE N-10

Degrees Conferred in B.S. Degree Nursing Programs, California Four-Year Institutions, 1972-1979

1978- 1979 46 136	182	92 129 58 54 36 103 212 137 118 96 70 1,287 103 78 40	
1977- 1978 51 140	191	77 107 125 62 33 132 199 241 97 84 106 1,263 57 76 58 39 377	
1976- 1977 48 140	188	55 78 110 73 34 105 94 74 87 63 44 81 68 33 346	
1975- 1976 81 132	213	46 91 114 65 29 29 100 129 77 77 73 35 343	
1974- 1975 43 182	225	38 92 128 87 39 83 178 59 84 80 114 29 83 73 28 110	
1973- 1974 38 79	117	62 89 105 55 22 72 76 76 79 56 130 979 979 14 63 31 105	
1972- 1973 49 90	139	57 70 129 20 21 74 47 84 57 119 767 767 767 767 20 46 45	
1971- 1972 40 67	107	61 95 14 141 141 105 81 97 704 704 704 704	
Institution UCLA UCSF	Total, UC	CSC, Bakersfield CSU, Chico CSU, Fresno CSU, Hayward Humboldt State U. CSU, Los Angeles CSU, Sacramento CSU, Sacramento San Diego State U. San Francisco State U. Total, CSUC Azusa Pacific Biola Loma Linda Mt. St. Mary's Pt. Loma Stanford U. of San Francisco U. of San Francisco Intil, Private Institutions	

*Azusa Pacific reported no graduates to HEGIS for 1976-77, but the institution reported 23 graduates in May of 1977 to the Board of Registered Nursing.
Sources: HEGIS; UC Statistical Summary; CSUC Statistical Reports.

There is also a group of programs which provide B.S. degrees for previously licensed nurses from associate degree or diploma programs. Table N-ll indicates the rapid growth in output of these programs.

TABLE N-11

Degrees Conferred in B.S Programs for Previously Licensed Nurses, California Four-Year Institutions 1973 - 1979

Institution	1972- 1973	1973- 1974	1974- 1975	1975- 1976	1976- 1977	1977- 1978	1978- 1979
CSU, Fullerton	-	_	-	11	28	53	49
CSC, San Bernardino	-	-	-	33	24	5	12
Sодоma State U	-	37	56	78	72	82	70
CSC, Stanislaus							27
Total, CSUC	-	37	56	122	124	140	158
Holy Names	-	_	_		•	_	
Univ of San Diego	5	NA	5	3	4	,	26
California Lutheran		 -		<u> </u>	12	24	22 3
Total, Priv Inst	5	-	5	3	16	31	51

Sources MESIS, Supplemented by data from CSUC Chancellor's Office

Data on the sex and ethnicity of B.S. graduates of State University nursing programs are displayed in Table N-12.

An examination of Table N-12 indicates that no progress has been made in the public four-year programs in graduating greater numbers of nurses from historically underrepresented ethnic groups. For Blacks, the percentage of nursing graduates has dropped from 7.5 to 5.1 in the last three years, and for Hispanics, from 4.6 to 4.2. The only underrepresented group showing a gain is male graduates, whose percentage went from 5.8 to 8.0 of the total during this period.

Ethnic data are not available for B.S. graduates of independent institutions, but Table N-13 displays data on the sex of graduates, reflecting an increase in the number of male graduates in nursing in these institutions.

TABLE N-12

Professional Degrees Conferred in Nursing, by Sex and Ethnicity California Public-Four-Year Institutions, 1976-1979

All	81 48 51 46	132 140 140 136	46 55 77 92	91 78 107 129	114 110 125 58	65 73 54	94 94 89 94 83 94 95
ta]	74 47 50 46	121 121 126 118	38 44 61 82	88 75 102 120	110 99 117 45	09 09 09 7	30 30 30 30
Total	1 1 1	11 19 14 18	8 11 16 10	шычо	4 11 8 8 13	12 12 CI 80	7 1 7 9
Other M F	ପଳ	7 8 1 1 1		교리	неен	440	e -
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No Resp.		5 10 3	t.	8 0 4 E	1 2 2 10	~ ~	6 6 1
		3.6		₽ ₩	2		7
Fflipino M	e	3 8 11 2	1			1 2	
		1	П				
White Non- Hispanic	30 30 30	77 80 84 86	32 33 74	74 60 62 72	91 81 90 32	41 52 43	23 17 30 23
\$ E E E	7	5 11 14	6 7 12 7	6000	3 8 6	2224	- e - e
Hispanic M F	9 8 8 4	4216	2641	ипп	9 7 8 1	1 1	7 1
된		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 2 2		-		-
Astan/ Pacific <u>Islander</u> M	12 7 12 6	9 16 20 16	3 1 3 1	- 44	26.11	™ ⊟ -	8
		3 5	7 7		2		
American Indian/ Alaskan Native N		H	ы	1	1 12		7 7
			1		-		
Black Non- Hispanic	96 6	5 8 8 7	E	6 4 4 4	147	9 7 1 1	
m <u>∓</u>]≥		1	1				
Non- Resident Alien M	8	F			7 -	3 5 -	
A Se ≥			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				5
			rsfie		g	Ē	state
	UCLA 1975-76 1976-77 1977-78 1978-79	UCSF 1975-76 1976-77 1977-78 1978-79	CSC, Bakersfield 1975-76 1976-77 1977-78 1978-79	CSU, Chico 1975-76 1976-77 1977-78 1978-79	CSU, Fresno 1975-76 1976-77 1977-78 1978-79	CSU, Kayward 1975-76 1976-77 1977-78 1978-79	Humboldt State U 1975-76 1976-77 1977-78 1978-79
	ŭ	'n	ប្	8	S	SS _	- -

TABLE N-12 (Continued)

	Non- Resident Alien	ŦΙ		American Indian/ Alaskan Native	Asian/ Pacific Islande	Asian/ Pacific Islander	Hispanic		White Non- Hispanic	Filipino		No Resp	Other N	, k.	Total M	A11	_l
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CSU, Long Beach			-		-	æ	c	_	99			4					7
1976-77	-		. vc	2) 4	, m		3.5			12		2	103	105	S
1977-78	• –					10	φ.	7	87	_		17	_				7
1978-79			- 00			60	νο.	.	61	-		17		υ,			e
CSU, Los Angeles																	
1975-76	7		63	7		20	19	_	84		-	œ		7			_
1976-77		2	6			91	1 5					ហ		ω,	5 89		4
1977-78		2	22	-		16	1 14	4	125	7	-	13		•	193	199	.
1978-79	က	1 2	6	-	-	11	15					23		٠,	203		7
CSU, Sacramento																	
1975-76	2		5			7	m	m -	1 57		e	23		-			0
1976-77			1			7	e				-	12	7	io i	69 <u>`</u>	7.	4.
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1978-79	4		·	7		9	νĐ				4	=	_	~			_
San Diego State U	Ω						ı										
1975-76			m		-	-	-	14						ង	26	(C) (C)	v r
16.6-77	•		,		-		·		5 5			-		Ω -			~ _
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19/8-19			.	7		~ 1	*1							₹			6
San Fran State U	n																
1975-76			~			7	_	-		2		7	7			2	0
1976-17		-	m	-		10				5			C)	-	. 62		~
1977-78			7	-		12		5	54	7		7	7				4
1978-79	-		vo.			12	1 2			9				c+ 3			•
San Jose State U																	
1975-76	pri	-	90	-		60	2 6		ლ ლ	-		16	_	2			o,
1976-77			4	-		10		2	7.4	П	7	14		S	105	110	
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1975-76	12	3 89	9	æ 0	س	79	5 50	3		*	•	77	18	20	-;		so i
1976-77	1 7		6	음 '	4	89				.	a	74			,		, .
1977-78				•	~ ·	% :	3 52		1,017	1 21	יני	102	1 15		1,374	1,454	4
1978-79	31	2	. 3		4	89				1 15	12	139			Ę,		'n

TABLE N-13

Degrees Conferred in B S Degree Programs, by Sex California Independent Institutions
1972 - 1979

_ 19	972	1973	1	974	Ţ	975	1	976	1	977	1978	1	979
М	F	M F	M	F	М	F	M	F	M	F	M F	M	
0	22	N/A	0	28	0	29	0	39	1	43	N/A	1	56
0	66	N/A	2	72	2	81	1	76	1			3	100
0	34	N/A	0	63	0	73	0	73	_				78
N,	/A	N/A	1	30	2	26	1	34	ì				36
1	78	N/A	1	104	2	108	1	118	1	119	N/A	3	122
	M 0 0 0	0 66 0 34 N/A	M F M F 0 22 N/A 0 66 N/A 0 34 N/A N/A N/A	M F M F M 0 22 N/A 0 0 66 N/A 2 0 34 N/A 0 N/A N/A 1	M F M F M F 0 22 N/A 0 28 0 66 N/A 2 72 0 34 N/A 0 63 N/A N/A 1 30	M F M F M F M 0 22 N/A 0 28 0 0 66 N/A 2 72 2 0 34 N/A 0 63 0 N/A N/A 1 30 2	M F M F M F M F 0 22 N/A 0 28 0 29 0 66 N/A 2 72 2 81 0 34 N/A 0 63 0 73 N/A N/A 1 30 2 26	M F M F M F M F M 0 22 N/A 0 28 0 29 0 0 66 N/A 2 72 2 81 1 0 34 N/A 0 63 0 73 0 N/A N/A 1 30 2 26 1 1 78 N/A 1 104 2 108 1	M F M F M F M F M F M F M F M F M F M F	M F M F M F M F M F M F M F M F M F M F	M F M F M F M F M F M F M F M F M F M F	M F M F M F M F M F M F M F M F M F M F	M F M F M F M F M F M F M F M F M F M F

Graduate degrees represent advanced specialization in nursing. The number of such degrees awarded, and the absence of any clear trends, are shown in Table N-14.

TABLE N-14

Graduate Degrees Conferred in Nursing
California Institutions
1973 - 1979

Institution	1972-73	1973-74	1974-75	1975-76	<u> 1976-77</u>	1977-78	1978-79
MASTER'S DEGREE PROGRAMS	5						
CSU, Chico	1	4	8	6	8	8	3
CSU, Fresno	16	12	18	14	5	11	8
CSU, Los Angeles	24	40	46	29	39	26	21
San Jose State U	14	9	12	15	19	12	12
CSU, Long Beach			-			8	18
Total, CSUC	55	65	84	64	71	65	62
UCLA	59	75	89	69	83	105	85
UCSF	137	153	51	149	1 5 5	134	98
Total, UC	196	228	140	218	238	239	183
Lema Linda	19	17	15	22	31	19	23
DOCTORATES DEGREE PROGRA	MS						
UCSF	2	7	4	3	2	8	5

Sources CSUC Statistical Reports; UC Statistical Summary, EEGIS

Dentistry

Enrollments in California's five dental schools, which are displayed in Table D-1, have registered only modest increases in recent years.

TABLE D-1
Fall Enrollment in Dentistry, California Institutions
1976 - 1979

				<u>Actual</u>								
School	1972	1973	1974	1975	1976	1977	1978	1979				
UCSF	317	333	339	352	377	384	401	411				
UCLA	395	420	428	425	426	425	406	425				
USC	497	502	500	519	508	511	521	584				
UOP	417	456	398	404	404	408	401	403				
Loma Linda	270	<u>273</u>	289	284	208	233	<u>255</u>	269				
Total	1,896	1,984	1,954	1,984	1,923	1,961	1,984	2,092				
Sources HRGIS, UC Statistical Summary												

The composition of this enrollment, by sex and ethnicity, is shown in Table D-2.

As Table D-2 indicates, the percentage of Black students enrolled in the University's two dental schools increased from 7.1 to 8.0 over the three-year period, but the percentage of those in private dental schools declined from 2 2 to 1.2. For Hispanics, at the University, the percentage grew from 11.6 to 14.6 during the same period; in the private schools, however, it declined from 5.7 to 4 9. Women constitute 22.7 percent of the University's dental enrollment, up from 19.8 percent three years ago, and 11.1 percent of the private school enrollment, up from 9.3 percent.

It seems reasonable to infer from these data that the percentage of Blacks and Hispanics enrolled in dentistry at California public institutions now closely approximates the last reported percentages that these minorities represent in the total California population (7.1% and 15.8%, respectively). These percentages of Blacks and Chicanos significantly exceeded those for both of these ethnic minorities in the eligibility pool of recent college graduates (4.6% and 4.9%, respectively)

TABLE D-2

408 401 403 뒴 478 406 425 387 401 425 865 807 850 255 269 511 521 584 1,142 1,152 1,177 1,256 1,914 2,017 1,984 2,106 Fall Enrollment in Dentistry, by Sex and Ethnicity, California Institutions, 1976-1979 Total 127 119 119 175 179 179 48 60 67 43 53 59 61 55 116 129 139 291 308 332 351 287 299 339 341 358 690 628 657 216 230 238 452 460 529 1,036 1,036 1,048 1,117 1,651 1,726 1,676 1,774 368 358 350 White Non-Hispenic 81 68 70 25 33 33 33 33 35 70 69 88 176 170 191 406 371 353 1,211 1,200 1,154 1,198 208 175 154 198 196 199 181 186 190 307 297 295 306 300 360 794 783 845 Hispanic N F 6 8 13 0.4 10 40 110 113 119 -0-0 9 9 24 25 25 99 95 105 54 50 51 45 54 54 54 147 160 37 39 45 45 50 55 Asian/ Pacific Islander 20 19 21 11 12 20 31 31 41 4 10 6 9 2 2 2 13 10 18 33 28 64 64 64 64 64 64 261 300 310 47 61 126 129 145 61 95 71 82 84 18 21 14 55 50 50 135 171 165 American Indian/ Alaskan Native M -000 7 0 0 7 -000 -000 17 7 17 8 Black Non-Hispanic 18 18 23 18 9 8 0 31 38 23 19 25 21 14 17 44 33 45 45 8 6 10 7 8 3 4 3 5 Non-Resident Allen 3 7 9 10 4 37 15 13 15 15 27 27 PRIVATE TOTAL 1976 1977 1978 1979 GRAND TOTAL 1976 1977 1978 1979 LOMA LINDA 1976 1977 1978 1979 UC TOTAL 1976 1977 1978 1979 UCLA 1976 1977 1978 1978 UCSF 1976 1977 1978 1979 UOP 1976 1977 1978 1979 USC 1976 1977 1978 1978

The number of degrees conferred in dentistry is depicted in Table D-3 on the following page. Considerable variation in output appears to occur from year to year, and no clear trend emerges.

The composition of the graduating classes in dentistry, by sex and ethnicity, is shown in Table D-4 for the last four years.

The apparent progress in admitting traditionally underrepresented minorities into the University's dental program is not yet reflected in graduation rates. In fact, over the past three years, the percentage of Blacks slipped from 4.6 to 4.3 of all graduating students even though Black enrollment increased from 7.1 to 8 0 during that time. Similarly, the percentage of Chicanos dropped from 10.3 percent to 8.1 percent of all graduating students, while enrollment increased from 11.6 percent to 14.6 percent. With women, however, increases in the percentage of the graduating class have exceeded enrollment increases: the percentages of graduates increased up from 9.2 to 16.8, while enrollment was climbing from 19.8 to 22.7.

In the three private dental schools, the percentage of Blacks in the graduating classes dropped from 2.7 to 0.0 over the three years, and the percentage of Hispanics from 5.3 to 3.2. Women constituted 8.4 percent of the 1979 graduating class in private dental schools, up from 5.9 percent three years earlier.

TABLE D-3

Professional Degrees Conferred in Dentistry, California Institutions, 1966-1979

Actual	1978- 1979	98	103	107	133	89	467	
	1977- 1978	88	901	134	127	73	528	
	1976-	9/	76	132	137	99	505	
	1975- 1976	89	85	147	125	99	512	
	1974- 1975	73	66	122	119	120	533	
	1973- 1974	7.7	93	124	191	69	554	
	1972- 1973	68	06	130	76	99	677	
	1971-	72	91	121	93	56	433	
	1970-	74	92	113	79	64	422	
	1969- 1970	73	74	118	19	29	385	
	1968- 1969	7.1	56	107	55	29	318	
	1967- 1968	89	27	101	58	55	309	
	1966-	70	;	82	94	27	255	
	1965- 1966	72	;	96	70	41	247	
	School	UCSF	% UCLA	nsc	UOP	Loma Linda	Total	

Source: John Wong Report, updated by HEGIS.

TABLE D-4

-1979 Profes

9/61	A11	85 94 106 103	89 76 88 82	174 170 194 185	66 66 73 68	125 137 127 133	147 132 134 107	338 335 308	512 505 528 493
S	41							നനന്ന	N N N 4
ution	Total M F	10 30 27 22	10 pt 80 pt	16 39 35 31	4440	8 14 11	7 20 11	20 23 35 26	36 62 70 57
Ethnicity, California Institutions,	E	75 64 79 81	83 67 80 73	158 131 159 154	61 62 69 64	117 123 116 122	140 127 114 96	318 312 299 282	476 443 458 436
ıia I≀	White Non- Hispanic	7 24 20 14	7987	9 30 25 27	4 m 4 4	7 11 8 8	2 5 10 8	11 19 20 18	20 49 39
iforr	2 T	51 49 47 62	61 56 49 38	112 105 96 100	49 50 61 51	103 103 97 103	97 93 75	251 246 233 230	363 351 329 330
', Cal	Hispanic M	0 10 0	0000	7010	0000	0000	0097	7097	40~7
icity	판	111 3 7 4 4	5 11 11	16 8 18 15	2 ⊢ ⊢ 2	~	111 111 7	16 13 8	32 21 27 23
Ethn	ffc ffc ffc	- 1 0 0 L	1 5 1 7	യയയ	0 1 0 1	3 3 7 7	1330	2 8 9 15	7 6 14 11
Sex and	Asian/ Pacific <u>Islander</u> M	9 4 17 8	11 3 12 24	20 7 29 32	~ ₩ ₩ ₩	9 15 18	22 22 12 12	38 35 43 36	58 42 72 68
by Se	can in/ in/ ish	0 7 0 0	0000	0-00	• • • •	0000	0000	0000	0 - 0 0
try,	American Indian/ Alaskan Native	1031	0010	- e	0000	0000	0402	0 7 0 7	1 7 7 8
Dentistry,	<u> </u>	3010	1110	4 1 2 0	-0-10	0000	000	0 1 0	2000
Ē	Black Non- Hispanic M F	6 6 7 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	3.85	8 9 17 7	0 1 0 0	0100	7 0 0	1- 1 9 0	115
nferred	# l.	• • • • •							
Conf	Non- Resident Allen	0 7 7 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	2321	2463	0 7 0 0	3 5 1 0	8 3 3 4 6 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, 0218
Degrees Co	~ '							7	10 15 11 8
		LA 1975-76 1976-77 1977-78	SF 1975-76 1976-77 1977-78	TOTAL 1975-76 1976-77 1977-78	LOMA LINDA 1975-76 1976-77 1977-78 1978-79	1975-76 1976-77 1977-78 1978-79	C 1975-76 1976-77 1977-78 1978-79	TOTAL PRIVATE 1975-76 1976-77 1977-78 1978-79	GRAND TOTAL 1975-76 1976-77 1977-78 1978-79
essional		UCLA 19 19 19	UCSF 19 19 19	UC 7 19 19 19 19	LOMA 19 19 19 19	8	USC 19 19 19 19	TOTA 19 19 19 19	GRAN 19 19 19 19

Pharmacy

Enrollment in the four pharmacy programs in California are shown in Table P-1. This enrollment appears to be relatively stable.

TABLE P-1
Fall Enrollments in Pharmacy, California Institutions
1971 - 1979

Institution/ Program	1971	1972	1973	<u>1974</u>	<u> 1975</u>	1976	<u> 1977</u>	1978	<u>1979</u>
UCSF Pharm D	353	362	378	386	399	417	450	443	457
USC Pharm D				532	573	N/A	603	609	605
UOP Pharm D	225	524	364	417	422	456	440	404	375
UOP B S	<u>254</u>	*	194	169	184	167	<u>151</u>	157	<u>163</u>
Total	832	886	936	1,335	1,578		1,644	1,613	1,600

*UOP reported a single enrollment total for the two programs

Sources UC Statistical Abstract, HEGIS, Institutions

The composition of enrollment in pharmacy, by sex and ethnicity, is shown in Table P-2 on the following page.

According to Table P-2, Black enrollment in the one pharmacy program in a public institution declined from 7.3 percent to 6.3 percent of the total during the past three years, while Chicano enrollment dropped from 7.3 percent to 6.6 percent. The percentage of women enrolled went from 46.3 to 46.8 during this time.

In the three pharmacy programs in the private sector, Black enrollment declined from 2.0 percent to 1.1 percent of the total, and Chicano enrollment from 4.6 percent to 3.8 percent. The percentage of women enrolled in pharmacy in the private sector climbed from 32.6 to 38.9 over the three-year period.

The number of degrees conferred in pharmacy is shown in Table P-3.

The composition of the graduating classes in pharmacy is shown, by sex and ethnicity, in Table P-4.

TABLE P-2

Fall Enrollment in Pharmacy, by Sex and Ethnicity, California Institutions, 1976-1979

A11	400 427 443	457	604 604	609 605	456 440 404 375	167 151 157 163
Total M F	215 185 229 198 228 215			369 240 371 234	331 125 291 149 248 156 219 156	98 69 90 61 94 63 108 55
White Non- Hispanic M	122 98 134 109 132 126	123	• • •	216 135 200 112	187 81 166 92 143 88 133 81	71 42 59 35 62 36 64 27
Hispanic M	24 5 22 5 21 5	σ, ,	0		16 4 8 5 6 7 6 6	66 65 4 4 6 6 8 3 3
Asian/ Pacific Islander M F	54 60 56 58 52 63	99 (123 79 129 83	96 23 95 39 75 48 64 60	16 19 14 19 20 19 31 20
American Indian/ Alaskan Native	000	0 (o 0	1 2 12 3 3 12	2 3 0 1 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	0 0 0 1
Black I Non- A Hispanic I	18 20 17		9 9		3 4 1 1	1 0 0 5 2
Non- B Resident Hi Alien Hi	4 11 6 13 4 17	4 17	-1	5 4 24 1	15 12 8 6 4	7 T T T T T T T T T T T T T T T T T T T
Re A	449	,		5 22	(Pharm D.) 76 31 77 19 78 21 79 10	.S.) 4 9 5 4 4
	UCSF 1976 1977 1978	280 -280	1976 1977	1978 1979	UOP (P) 1976 1977 1978 1978	UOP (B 1976 1977 1978 1979

TABLE P-3

Professional Degrees Conferred in Pharmacy California Institutions 1966-1979

1978- 1979	16	136	144	07	417
1977-	85	140	133	46	407
1976- 1977	16	771	137	19	431
1975-	61	126	165	45	397
1974- 1975	78	121	152	45	402
1973- 1974	78	131	130	62	407
1972- 1973	7.8	113	91	127	607
1971-	83	66	36	09	278
1970-	98	114	30	. 71	301
1 969- 1970	81	96	22	78	277
1 968 -	11	82	Т	56	210
1967- 1968	79	122	2	62	265
1966- 1967	62	93	6	59	217
1965- 1966	80	66	ю	42	224
School/ Program	UCSF Pharm D	Pharm D	Pharm D	B S	Total

Source John Wong Report, supplemented by MEGIS

TABLE P-4

Degrees Conferred, Pharmacy, by Sex and Ethnicity

	¥	61	91	88 F	6	126	142	141	136		165	137	133	144		45	19	94	40
	M F		41				77				45	27	37	48		15	21	18	23
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As Table P-4 indicates, the percentage of Black graduates in pharmacy at the University went from zero in 1975-76 to 7.2 in 1978-79, and the percentage of Chicanos, from 3.3 to 4 l. In the three programs in independent institutions, the percentage of Black graduates went from 1.2 to 2.2, and that of Hispanics, from 0.9 to 1.3. For women, the percentage of pharmacy graduates at the University jumped from 36.1 to 50.5 over the three-year period, marking the first time that women have outnumbered men graduates in a professional program in the health sciences, other than nursing. In the independent sector, the percentage of women pharmacy graduates rose from 29.2 to 38.4 during the same period.

Optometry

Relatively stable enrollments in California's two professional programs in optometry are shown in Table 0-1.

TABLE 0-1

Fall Enrollments in Optometry, California Institutions 1972 - 1979

	<u>Actual</u>													
Institution	<u>1972</u>	1973	1974	<u>1975</u>	<u> 1976</u>	<u>1977</u>	<u>1978</u>	1979						
UC, Berkeley	232	238	251	261	270	257	257	262						
Southern California College of Optometry		314	367	371	390	397	387	390						

Source John Wong Report, updated by MEGIS; projections from institutions

Table 0-2, on the following page, shows enrollment in optometry, by sex and ethnicity, during the past four years

At the University, Black enrollment in optometry declined from 4.0 percent of the total to 2.7 percent, while Chicano enrollment increased from 5.1 percent to 5.7 percent. The percentage of women enrolled in optometry has declined from 27.3 to 23.7 of the total. In the State's one private optometry school, the percentage of Black enrollment has risen from 0.5 to 1.3, and that of Chicanos from 2.8 to 3.3. Enrollment of women in this program has shown a dramatic increase over the three years, from 8.2 percent of the total to 23.3 percent.

Degrees conferred in optometry are shown, by sex and ethnicity, in Table 0-3.

At the University, the percentage of Black graduates in optometry declined from 1.7 to 0.0, while an increase from 1.7 to 3.1 was taking place for Chicanos. For women graduates, the percentage remained almost constant during this period, rising only from 21.7 to 21.9. In the private optometry program, no Black students were graduated in either of the comparison years. For Chicanos, the percentage of the graduating class dropped from 3.2 to 3.0; for women, the percentage increased from 6.3 to 6.9.

TABLE 0-2

Fall Enrollment in Optometry, by Sex and Ethnicity, California Institutions, 1976-1979

ļ	AI.			253	255	257	262		390	397	387	390		643	652	949	652
	Total	⊥ ∑				198 59					325 62					523 121	
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			UCB	1976	1977	1978	1979		1976	1977	1978	1979	TOTAL	1976	1977	1978	1979

TABLE 0-3

Degrees Conferred, Optometry, by Sex and Ethnicity

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Osteopathy

Osteopathy is included in the <u>Health Sciences Education Plan</u> this year for the first time. There is one institution of osteopathy in California, the College of Osteopathic Medicine of the Pacific, located in Pomona. The institution is relatively new, and has yet to graduate its first class.

Enrollments at the institution are shown below:

Non-		Am. Ind./	Asian/	White						
Resident		Alaskan	Pac.	Non-						
Alien	<u>Hispanic</u>	<u>Native</u>	Island.	<u>Hispanic</u>	<u>Hispanic</u>	Total				
M F	M F	M F	M F	M F	M F	M F				
0 0	1 0	0 1	5 0	1 0	70 13	77 14				

The fact that California's only educational program in osteopathic medicine is new is a reflection of the history of the profession in the State. Most California osteopaths became licensed as medical doctors in 1962 as a result of Proposition 22 of that year, a circumstance which obviated the need for osteopathic education. At that time, the only institution in the State offering education in osteopathic medicine was converted to a public allopathic medical school which is now part of the University of California, Irvine.

For twelve years after that date no provision existed in law for new licensure of osteopaths, although several hundred osteopaths who did not want to become medical doctors continued to practice under their existing licenses. In 1974, the State Supreme Court struck down the provisions of the 1962 law which had eliminated new licensure. Since that time, osteopathy in California has grown, with about 450 practitioners now licensed as osteopaths. This growth within the profession created the pressure for the new educational program.

Osteopathy has been identified by a recent Kellogg Foundation study as the fastest growing health profession. There are now fourteen osteopathic medical schools in the United States, with another school scheduled to open in 1981. Several of these fourteen are state institutions, and several others receive some state support. Only one institution is located in the western states, the College of Osteopathic Medicine of the Pacific.

About 1,300 graduates a year are added to the profession, which now numbers about 19,000 osteopaths nationally, all of whom have full parity with medical doctors under state and federal laws. Although some osteopaths may specialize, about 75 percent of osteopaths are engaged in primary care.

Podiatry

Podiatry is also being included in the Plan for the first time. One institution exists, the California College of Podiatric Medicine, in San Francisco. Through its ties with the University of California, San Francisco, this independent institution is receiving \$747,000 annually in State support.

Enrollments and graduation rates of the institution are shown below:

	Non- Resident Alien		Black Non- Hispanic		Am. Ind./ Alaska <u>Native</u>		Asian/ Pac <u>Island.</u>		Hispa	<u>anic</u>	₩h1 No <u>Hisp</u>	n-	Ţo	Total	
1979 Fall	m	r	m	F	17	Г	FF	r	Ę	r	PF	r	-	F	
Enrollment	9	1	1	3	0	0	28	8	4	0	297	45	339	57	
1978-79 Graduates	0	0	1	0	0	0	3	0	2	0	79	9	85	9	

In one sense, it would be relatively easy to respond narrowly to the statutory mandate for this report by concluding that the capacity and output of California's health sciences education programs are entirely adequate to meet the State's overall needs for trained professionals in each field. But the Commission would be ignoring part of its responsibility if it did not note that participation in such educational programs have not been shared equally by all ethnic groups. The progress achieved by public institutions in admitting women to health sciences education programs clearly indicates that the historical mix of students in these programs can be balanced. The challenge now is to achieve a comparable balance in ethnicity.

SECTION B: DISPOSITION OF RECOMMENDATIONS FROM THE COMMISSION'S 1978 PLAN

In its 1978 <u>Health Sciences Education Plan</u>, the Commission addressed problems with long-range policy implications, as well as those which could be resolved within the two-year life of the Plan. A summary of those recommendations together with their current status, follows.

In medical education, five recommendations were made.

1978 Recommendation

- 1. Because of the large and growing number of physicians now practicing or receiving graduate medical education in the State, no additional medical schools or sub-campuses of medical schools should be implemented or phased-in in California until the rate of in-migration drops markedly During this time, existing and currently planned two-year programs should not be expanded beyond two-year status.
- 2. The State should determine the mode and degree of State influence on medical education programs, particularly residencies, which would achieve the most beneficial results in effecting desired distribution of medical specialties and optimum utilization of medical education as a means of providing health care in underserved areas

Current Status

No change has occurred in the status of any medical school or program. Third-year students at the University of California's Los Angeles campus have not yet been assigned to the Charles R. Drew Postgraduate Medical School. The first such students should enter Drew in 1983-84. Looking to that event, the Commission has been asked by the Legislature to determine if some 250 postgraduate students projected for Drew should be funded as University-affiliated residents.

Several steps have been taken to address the problem of residencies. Control language in the 1980-81 State Budget requires that the University of California develop a detailed justification of any changes in the number and types of residencies, and submit that justification in connection with its 1981-82 Health Sciences Budget. Also, an advisory committee on graduate medical education has been organized under the auspices of the Office of Statewide Health Planning and Development Legislation requiring

an extensive study of residencies failed to emerge in the final days of the 1980 session. However, the Legislature imposed budget language on the University reducing the number of State supported residencies by ninety-nine

3. The health manpower and health science education planners of the State should develop standards for assessing the adequacy of the total health care which is available to urban and rural Californians, reflecting normal patterns of mobility but taking into account the barriers—cultural, linguistic, economic, and psychological—which may affect the utilization of existing health care resources.

Progress seems to have been made in clarifying the designation of "underservice" in primary medical care. However, there is still a constant shuffling of medical service study areas (and even census tracts) from one designation to another Also. State health planners have redefined primary care in such a way as to divorce it from total health care. On the other hand, the statewide AHEC (Area Health Education Center), has taken a broader view of primary care in developing programs to increase the effectiveness of a number of types of health professional, and has developed its own approach to the assessment of community health care needs.

4. The State should provide for the certification of nurse practitioners and should further define this profession and the scope of its practice. The educational and experiential requirements for certification should be established at a standardized professional level, but should provide for a variety of paths to the attainment of those requirements.

Senate Bill 666, which provided for certification of nurse practitioners, died in the Legislature. For further discussion of the status of nurse practitioners see the section of the current Plan dealing with geriatric nurse practitioners.

 The State should encourage, through appropriate means, the recruitment of medical

Fairly extensive efforts have been made to increase the diversity of medical school students and residents from diverse backgrounds, cultures, and languages, and should encourage, through the medical education programs it supports, the development of sensitivity on the part of physicians to the needs of people as individuals and as members of diverse cultures and groups.

student bodies. In addition to those efforts described in the Commission's first Plan. further impetus for recruiting health professionals from underrepresented groups has been provided by the Statewide Area Health Education Center Project, administered by the University's San Francisco Medical Center. Opportunity programs are an integral part of this Project, which is designed to individualize the training of primary care personnel. With the numerous career opportunity, affirmative action, and outreach programs now in operation, there is now a need to coordinate and evaluate such activities.

Two recommendations were made in the 1978 <u>Health</u> <u>Sciences</u> <u>Education</u> Plan, relative to the field of nursing.

The Postsecondary Education Commission, together with the Division of Health Professions Development in the Office of Statewide Health Planning and Development, should jointly establish a task force to make a differentiated assessment of statewide nursing-care needs manpower resources. This group should be made up of nursing educators, health planners, hospital spokespersons, legislative staff, representatives of licensure boards and professional associations, working nurses, et al. The task force should explore ways of determining the supply of and demand for nurses, including specialists; resolve problems in the education, employment, and retention of the proper number and types of nurses;

Limits on staff time and resources have delayed the organization of this study. Discussions on this topic have continued, however. the end of the 1980 session an attempt was made through a legislative resolution to point up the importance of a study on nursing attrition in order to give a private professional association some leverage in obtaining grant funds to carry out such a study. The resolution, however, did not pass.

and assist various agencies and organizations to work together toward fuller utilization of nursing manpower resources.

2. In order to achieve better coordination and articulation, the two boards now licensing nurses—the Board of Registered Nursing and the Board of Vocational Nurse and Psychiatric Technician Examiners—should be combined into a single board with responsibilities for all licensure of patient—care personnel.

Legislative efforts to accomplish this goal through Senate Bill 666 were not successful. The bill may have been too comprehensive, in that it also sought to provide for certification of nurse practitioners and other specialists, greater Board control over career ladders, a dominant position for RNs in the membership of the joint Board, the eventual elimination of the category of psychiatric technician. the elimination of continuing education requirements, the use of competency-based examinations for licensure, etc. These extensive changes may have prompted a number of groups to join together in opposing the bill.

Three recommendations, all concerning use of auxiliary personnel, were made in the field of dentistry.

- The State should clarify the scope of practice of extendedfunction dental auxiliaries, and should provide educational programs to prepare Californians for these para-professional fields.
- In general, there has been little change in the status of dental auxiliaries. A bill to place a dental assistant and a dental hygienist on the Board of Dental Examiners died in the Legislature, as did a bill to permit the practice of denturism in California. A bill to authorize dental hygienists to incorporate and practice as dental corporations passed.

 Greater use should be made of expanded role dental auxiliaries, particularly in meeting dental needs in underserved areas.

See 1 above

 Additional minority students should be recruited for careers of facilitating community screening and peer counseling which will provide assistance and support to people in underserved areas who need further dental care. See 1 above.

Only one recommendation in the 1978 Plan dealt with the field of pharmacy.

1. The State should provide in statute and regulation for the delineation of function between a professional pharmacist and a pharmacy technician, and should provide appropriate educational programs in each field, taking into account the variety of roles which pharmacists may fill, ranging from traditional retail dispensing of drugs to the delivery of primary health care.

A bill authorizing the use of pharmacy technicians in pharmacies was introduced in the Legislature, but died in committee.

Two recommendations were made in the 1978 Plan concerning optometric education and personnel.

- The State should include optometry in the AB 1503 experimental health manpower programs in order to explore possible new roles for optometrists in primary health care, and for optometric technicians in patient care.
- 2. Future health manpower plans prepared by the Office of Statewide Health Planning and Development should investigate the overlapping responsibilities of optometrists and ophthalmologists in providing vision care, and should recommend public policies with respect to the utilization of each kind of vision specialist.

The Division of Health Professions of the Office of Statewide Health Planning and Development reports that optometry, while not mentioned in AB 1503, is eligible for experimental manpower programs under the category of "other".

The 1979 Health Manpower Plan incorporates this recommendation and the OSHPD proposes to examine the issue through the study of graduate medical education it is conducting.

With respect to increasing educational opportunity in the health sciences for historically underrepresented groups, the 1978 Plan offered four recommendations.

- California institutions should continue outreach, recruiting. and admissions programs to increase the number of minority and women undergraduates as a means of increasing the numbers eligible for programs in the health sciences.
- A wide variety of outreach, recruiting, and admissions activities in California institutions suggest that this goal is a high priority at both the campus and the systemwide levels. The data on enrollments and graduation rates, presented earlier, however, indicate that uneven progress toward this goal has been made in some areas of health sciences education.
- 2. Monitoring of educational opportunities in the health professions should be a part of any ongoing monitoring of affirmative action activities by segmental headquarters and such agencies as the California Postsecondary Education Commission. As a result of such monitoring, those special State and federal programs presently operating to increase enrollment of ethnic minorities and women in the health sciences should be evaluated by January 1, 1981, to determine their effectiveness.
- The Commission's monitoring activities in the areas of educational opportunity and affirmative action have been increased through State budget language and through Commission action. Although additional Health Careers Opportunities Programs have been launched with federal money, no evaluation of existing federal and State programs has yet been made.
- 3. California institutions should continue to recruit and admit additional, qualified ethnic minorities and women in the health sciences to offset the historic underrepresentation of these groups. Women, as a group, are underrepresented in proportion to their numbers as college graduates, as well as their numbers in the total popu- versing a four-year decline. lation. They should be given special priority in these recruiting and admission efforts.

The Health Career Opportunity Program in the Office of Statewide Health Planning and Development quotes enrollment figures from the Association of American Medical Colleges, and asserts that minority admissions to California medical schools in 1979 increased 21 percent over the previous year, re-Enrollment data collected by the Commission also show continued progress in bringing greater numbers of women into health sciences programs in greater numbers As noted

elsewhere in this report, progress in affirmative action seems to have been achieved in medicine and dentistry. Somewhat less progress is evident in nursing, pharmacy, optometry, osteopathy, and podiatry.

4. All entities of State government which support, govern, or administer education, from the Legislature to local campuses and public school systems, should increase their efforts to identify and overcome those barriers which have prevented minorities and women from participating fully in professional education in the health sciences. Such efforts should be assigned high priority in the allocation of public resources of time and money.

It is difficult to assess the effectiveness of individual approaches, components, or activities of any public agency or institution in achieving progress in expanding educational opportunity for underrepresented groups. The 1978 recommendation reflects the fact that the responsibility for achieving such progress lies with a variety of people and agencies.

SECTION C: SUMMARY OF RECOMMENDATIONS IN OTHER HEALTH-RELATED PLANS

In developing its <u>Health Sciences Education Plan</u>, the Commission is required by the <u>Education Code</u> to "take into account" the <u>Health Manpower Plan</u> issued biennially by the Office of Statewide Health Planning and Development. The second such plan developed by that agency was produced in 1979, and contains a number of recommendations on health manpower which have a bearing on health sciences education

Moreover, a new State Health Plan has been issued for the first time since 1971. This document, which is discussed later in this section, contains recommendations on manpower and other aspects of health which are relevant to health sciences education. The recommendations from these two Plans follow, together with Commission response.

Health Manpower Plan

Recommendations on Physicians

(Repeated from the 1977 Plan)

- 1. No action should be taken at this time to increase the overall supply of physicians in California.
- 2. The State should increase its encouragement of primary care residency training programs located in rural physician shortage areas and should support the recruitment and admission of persons with rural backgrounds into medical schools

(Modified from the 1977 Plan)

3. The State should evaluate the effectiveness of existing mechanisms and explore other strategies to influence the location of pri-

Commission Response

The Commission endorsed Recommendations 1 and 2 in its 1978 Health Sciences Education Plan.

The Commission had no disagreement with Recommendations 3-7 in its 1978 <u>Health Sciences Education Plan.</u>

mary care physicians and non-physician medical practitioners in urban and rural geographic shortage areas.

- 4. As an overall state goal, within five years, 50 per cent of physicians entering practice in California should be principally engaged in the delivery of primary care services.
- 5. The Office of Statewide Health Planning and Development, the Postsecondary Education Commission, and the training institutions should collaborate on research for further evaluation of the numbers needed and deployment, quality of care provided, extent and nature of collaboration with physicians, public acceptability, and cost/benefits of training and utilizing physicians' assistants and nurse practitioners in California.
- 6. Pending additional research findings, the State should continue to support and encourage the expansion and development of training programs for primary care nurse practitioners and primary care physicians' assistants in sufficient numbers so that the positive contribution to health care services they have already demonstrated can be fully explored. The

State should encourage development of appropriate methods for their reimbursement by third-party payers and should modify administrative regulations so that they can be fully utilized.

- 7. The State should continue to support existing mechanisms such as the Song-Brown Family Physician Training Act, to increase the number of family practice residents training in California with priority emphasis on those programs which are located in or have strategies oriented towards rural and inner city shortage areas
- 8. Fifth-Pathway programs as presently constituted should be continued only through June, 1981. The Office of Statewide Health Planning and Development, in cooperation with the Health Manpower Policy Commission, the California Postsecondary Education Commission and other interested groups, should develop a plan for restructuring Fifth-Pathway programs so that entrance into them thereafter is conditional on participants contributing to meet specific state geographic and specialty goals.

The Commission concurs that Fifth-Pathway programs should be restructured into a plan to require a commitment to service in an underserved area in return for admission to the extra year of clinical training.

(New Recommendations)

- 9. For purposes of health manpower planning, primary care should be redefined as "comprehensive primary medical care" and "limited primary medical care" and physician specialties categorized accordingly.
- 10. Effective in Fiscal Year 1980-81, there should be an increase in first-year positions in family practice, in accordance with a phase-in plan that would increase the total number of first-year positions to 400 within five years, as compared to a current number of approximately 200 first-year positions.
- 11. The medical education sector should recognize the potential consequences of excesses or imbalances in the supply of specialist physicians and should develop, in cooperation with state planners and other agencies, a voluntary alternative to state regulatory mechanisms.
- 12. The State should support existing mechanisms such as the Song-Brown Family Physician Training Act to expand team-training programs for primary care physicians, primary care physician assistants and family nurse practitioners in rural and inner city shortage areas.

This definition may be useful to those concerned with the details of planning medical care; however, it moves away from the concept of primary health care, a concept which makes use of nonphysician health care providers.

This recommendation should be held in abeyance until: (1) the University of California, presents its rationale for the development of residencies as required in supplemental language in the 1980-81 State Budget; and (2) the impact of the new statewide Area Health Education Center (AHEC) project on primary care residencies is determined.

The Commission concurs with Recommendations 11-13.

13. The State should consider changes in the methods and relative reimbursement rates in the Medi-Cal and other publicly funded medical care programs that would result in financial advantages to those primary care physicians and other primary care providers who choose practice locations in underserved rural and urban areas.

Recommendations on Dental Personnel

(Repeated from the 1977 Plan)

- 14. Significant numbers of California children and adults, especially among low income and ethnic minority groups, have serious dental problems that are not being helped. State policy should encourage and support programs to meet this need through dental health education, dental services, and environmental measures to prevent dental disease.
- 15. The State should actively promote the fluoridation of community water supplies as the most important single step to prevent dental cares and to free dental health manpower for functions that will prevent and treat other oral pathology.

The Commission had no disagreement with Recommendations 14-18 in its 1978

Health Sciences Education
Plan.

- There should be no special State Initiatives to increase the numbers of dentists trained in California unless the increases are targeted to service in underserved areas or to underserved populations. This recommendation should be contingent on preparation and use of adequate numbers of dental auxillaries and increases in the proportions of minority personnel in dental health occupations.
- 17. Full development of regulations for the training and utilization of expanded role dental assistants and expanded role dental hygienists as authorized by AB 1455, 1974, should be completed.
- 18. The State should encourage and financially support, if necessary, experimentation with the training and utilization of expanded role mid-level auxiliaries who will perform a broad range of preventive, screening, and dental care functions under the general direction of a dentist.

(New Recommendations)

19. The State should permit independent practice by licensed dental hygienists, so that their services are fully accessible to the public, especially in organized, cost-effective service settings.

The Commission concurs in principle, inasmuch as this position is consistent with implicit support of free-standing dental hygienists in its 1978 Health Sciences Education Plan. The Commission suggests a pilot-project approach to this

recommendation in order to insure that the concept is fully tested before implementation.

20. The State should encourage a limited number of pilot projects for the evaluation of the training and utilization of denturists so that acceptability, safety and desirability of their legalization in California can be tested before regulatory laws are changed.

The Commission concurs in principle with this recommendation.

Recommendations on Nursing Personnel

(Modified from the 1977 Plan)

State initiatives simply to increase overall supply of nurses should not be undertaken. Any expansion should be specifically targeted toward such goals as solving problems of chronic Job vacancies; increasing the supply in underserved geographic areas; increasing the number of needed nurse specialists, such as family nurse practitioners, intensive care nurses and geriatric nurses; increasing the number of nurses who are prepared to serve actively in rural and urban shortage areas of the State and increasing the number of nurses who can work effectively among bilingual and multi-cultural populations.

The Commission concurs with Recommendations 21-23

(New Recommendations)

- 22 The State should institute and maintain a system of regular and comprehensive collection and analysis of basic data on all nurses licensed in California, based on a regular reporting procedure required of all licentiates, and capable of making available such essential planning data as numbers, location, employment status, practice specialty, potential availability, and other information necessary to anticipate needs and to facilitate planning for appropriate distribution of nurse personnel supply.
- 23. In order to employ all feasible measures that will maximize participation of credentialed nurses in active practice, the State and appropriate organizations such as the California Nurses' Association, the California Hospital Association and the Califormia Association of Health Facilities, should analyze the findings of existing research studies and should collaborate to conduct any further studies of California nurses necessary to better understand the social, psychological, economic and employment environment factors responsible for the high rate of job turnover among nurses, includ-

ing the "burn-out" and frustration of well-credentialed RNs.

- 24. Nursing educational programs should study and incorporate processes of student selection and academic and clinical training of nurses so that those selected and trained are those most likely to practice actively and work in locations where most needed. Where necessary, applicable state policy and regulations governing admissions should be changed to allow for this. Nurse training should include thorough orientation to the realities of actual work, and experience, including clinical training in diverse settings and on different work shifts, in a variety of levels of function and involving realistic stress and workload expectations.
- 25. Organizations and institutions that employ nurses -principally hospitals and nursing homes -- should continue to study and implement all changes feasible directed to improving those aspects of the work setting and employment conditions of nurses that will make active and sustained professional practice more attractive. These changes should include, but not be limited to, optimum and equitable pay and ben-

The Commission concurs that attention should be given in the admission process to candidates who are psychologically suited to nursing, and that nurse training should make use of diverse settings and time frames to achieve realistic training situations. Admitting only those candidates who are psychologically suited to nursing may pose difficulty for the Community Colleges, where the open-door admissions policy prevails. However, the Commission believes that institutions generally can make such modifications without changes in "state policy and regulations."

The Commission concurs with Recommendations 25 and 26.

efit packages, flexible shift and hours arrangements, child care facilities, easier access to continued (sic) education, more opportunity for nurses to assume professional practice responsibilities and roles appropriate to their training, and should involve system changes to increase the status and personal job satisfaction of nurses.

26. The State should continue existing mechanisms, such as stipends, salary incentives and deferred or cancelled loans, based on commitments to serve in need areas, and should expand public health service corps programs and should explore other strategies to encourage location of nurses in shortage areas of the State.

Recommendations on Optometrists

(New Recommendation)

27. A special sub-task force made up of representatives of the fields of ophthal-mology and optometry should be constituted to function as a part of the collaborative process now being undertaken to study graduate medical education in California. The sub-task force should determine and recommend the appropriate roles and utilization of

The Commission concurs, inasmuch as this recommendation responds to an issue identified in the 1978 <u>Health Sciences</u> Education Plan

ophthalmologists and optometrists in the delivery of cost-effective vision care.

Recommendations on Pharmacists

(Repeated from the 1977 Plan)

- 28. The professional role of pharmacists in the delivery of primary health care should be expanded to make maximum use of the scope and nature of professional pharmacy education.
- 29. The State should encourage and support further experimentation with training of pharmacy technicians for functions as expanded role pharmacy auxiliaries and the training and utilization of such personnel should be evaluated for quality of care, public acceptability and cost/benefits.

The Commission endorsed Recommendations 28 and 29 in its 1978 <u>Health Sciences</u> Education Plan

Recommendations on Minorities

(Repeated from the 1977 Plan)

30. The State should provide more active support of programs that promote the preparation, acceptance and training in medical schools and other health professional schools of increased numbers of persons from underrepresented minority backgrounds, who will have a high likeli-

In its 1978 Health Sciences
Education Plan, the Commission concurred with Recommendations 30 and 31, and made strong recommendations of its own on this subject. The Commission also pointed out the absence of definitive studies showing a relationship between place of origin and place of practice. The

hood of practicing in minority health manpower shortage areas.

The State should provide active support, including financial support, to efforts to increase the number and proportions of underrepresented minorities in the health professions.

Commission suggested that increased minority enrollment in health professions education be viewed as a goal in itself--as a means of providing increased opportunity for historically underrepresented groups and for greater diversity within the profession.

(New Recommendations)

- 32. California should seek a larger share of federal funds and, for more immediate and direct effect, should establish State funding for an appropriate number of community, student or school based health professions recruitment and retention projects.
- Regarding Recommendations 32-34, the Commission concurs in principle with the need to make special efforts to recruit additional minorities. In its 1978 Health Sciences Education Plan, the Commission recommended that such special efforts be evaluated to determine their effectiveness. The Commission is not aware that any such evaluations have been conducted.
- 33. The number of minority biomedical support type programs on college campuses should be increased through more vigorous pursuit of NIH funds, direct state funding or redirection of existing funds to such programs.
- Summer undergraduate prehealth professional pre-

paration programs should be instituted in California through funding sources identified in No. 33 above.

Admissions procedures to California's health professional schools should be restructured so that the admissions mechanisms result in increased probability that the priority health professional manpower needs of the State are met.

While broad admissions guidelines are matters of public policy, the admissions procedures referred to in Recommendation 35 are generally the prerogative of the institution. The implication of State intervention in admission procedures raises a sensitive issue The 1978 Health Manpower Plan proposed a quota system which would limit, by specific percentages, the number of students who could enter a particular area, such as research, family practice, etc. Such a system would force students to elect a career pattern without adequate knowledge of the practice of medicine. It also would threaten the tradition of free choice for California medical students.

36. The number of health service corps placements of health professionals in "barrios" and "ghettos" in California should be increased as a shortterm measure to make health services available and accessible to persons living in those areas.

The Commission concurs with Recommendation 36, inasmuch as it is similar in principle to one made by the Commission in the 1978 Health Sciences Education Plan.

Recommendation on Women

(New Recommendation)

37. The State should employ all feasible means to increase the proportion of women in health professions toward eventual parity. Efforts should focus on mechanisms to enlarge the applicant pool, the initial enrollment levels, and the retention of trainees. Numbers of women advisors. faculty and counselors should be increased for recruiting, assisting and acting as role models for women in health professions.

The Commission concurs with Recommendation 37. In its 1978 Health Sciences Education Plan the Commission criticized the 1977 Health Manpower Plan for not devoting any attention to women as an underrepresented group in the health professions Thus, this addition of this recommendation is encouraging.

Other Recommendations

(Repeated from the 1977 Plan)

38. All health professions education should include strong components from the field of social and behavorial sciences and humanistic studies, and understanding of the approaches of holistic health, a knowledge of the capacities of other health care personnel, and training in referring patients to other members of the health team and collaborating in treatment cooperatively with other health disciplines.

(Modified from the 1977 Plan)

39. Proposals for National Health Insurance should be analyzed for their impact on California health The Commission endorsed Recommendations 38-40 in its 1978 Plan.

manpower requirements including the optimum use of health manpower for primary medical and dental services, including preventive health services, and also as to their provision for reimbursement of physicians' assistants, nurse practitioners, and other new health practitioners.

40. State health manpower policy should support the
training of personnel prepared for health promotion and illness prevention and to provide leadership to the redirection
of the health care system
toward these ends.

(New Recommendations)

- 41. State legislation should be enacted to place all categories of nursing personnel under the jurisdiction of one credentialing and regulatory board.
- State legislation should be enacted to establish administrative mechanisms to evaluate proposals for the credentialing of existing, but currently noncredentialed, categories of health personnel. Proposals for new categories of health personnel and for expanded scopes of practice should be evaluated for need and feasibility under the existing administrative mechanism, health manpower pilot projects (AB 1503).

The Commission concurs, inasmuch as a similar recommendation was made in its 1978

Health Sciences Education

Plan.

The Commission concurs with Recommendations 42-44.

- 43. The State should seek the active participation of the federal government in the development and validation of competence-assurance standards and criteria.
- 44. The State should review all existing structures and procedures for the credentialing of health personnel, to determine what may be abandoned, or merged, or otherwise changed to eliminate redundancies and unnecessary requirements or procedures

State Health Plan

The Commission is not required to review the <u>State Health Plan</u> in the same sense in which it "takes into account" the <u>Health Manpower Plan</u>. However, the Commission feels that the former document contains some observations on health manpower which perhaps are more comprehensive than those of the latter document and therefore worthy of note.

The State Health Plan is produced by the Office of Statewide Health Planning and Development (OSHPD), but in a section separate from the Division of Health Professions Development which produces the Health Manpower Plan. Under the National Health Planning and Resources Development Act of 1974, (Public Law 93-641) the OSHPD is required to prepare a preliminary State health plan annually, consisting of the plans of the fourteen Health Systems Agencies throughout the State. The Act also requires the State Health Coordinating Council to produce an annual State health plan which reflects the preliminary State health plan.

California has never created the State Health Coordinating Council required by federal law, nor has the State mandated a State health plan under any other aegis. Thus, the Plan produced by the OSHPD attempts to carry out the spirit of the federal legislation in the absence of the prescribed mechanism to do so. As such, it is an interesting and provocative look at the health care needs of California's citizens. The Plan has been criticized as being an iconoclastic attack on the present health care system, and a grandiose and unrealistic design for a new mode of health care. It has also been defended as a courageous, insightful, and timely attempt to reorient the State's responsibilities in health toward greater cost-effectiveness and better health.

The tone can be detected early in the Plan when the authors identify four "realities":

- Individual behavior, choice and attitude play a major role in the ethology, management, and cure of disease, not to mention the promotion of health.
- . Resources of the earth are finite--which is not necessarily to say in short supply but simply not infinite.
- . The health care system, in its organization, financing and philosophy, has not been concerned with promotion of health.
- . Perverse incentives in that system are creating a service too expensive to be universally available in desired amounts.

The Plan assumes that the level of health experienced by an individual or a society is the product of four related but distinct factors: human biology, environment, behavior, and health care services. In order for California to develop policies which encourage the optional functioning of these factors, six priority issues must be addressed.

- . improving health status
- . controlling the cost of health care
- supply and regulation of health personnel
- . the future of publicly financed health services
- . planning for health systems with statewide impact
- . coordination of existing State health policies.

For each issue a set of policy recommendations is made. Of particular relevance to this report are those recommendations for the supply and regulation of health personnel. These recommendations and a short rationale for each appear below, together with the Commission responses.

State Health Plan

Recommendations on Supply and Regulation of Health Personnel

 The tasks, functions, and roles of many health care practitioners should be recognized as frequently overlapping and potentially interchangeable for many purposes.

Rationale: Effective planning for and use of health personnel must begin with the acknowledgement that many distinctions among types of personnel are barriers to flexibility, mobility, and innovation.

2. Improvements in access to health care services should be achieved in the future through better organization of services, changed reimbursement patterns, improved physician productivity, and innovative use of non-physician manpower, rather than through increases in total supply of physicians

Rationale: There are many ways to overcome remaining problems of access to health care. Physicians are more expensive to educate, remunerate, and back up than any other health professional. Physicians are not needed for many tasks they could and have delegated.

Commission Response

In its 1978 Plan, the Commission identified this overlap and potential interchange-ability as a problem for the planner, particularly since all health professions prepare their personnel as though they were discrete units of health care delivery rather than part of a spectrum of health care providers.

The expanded use of mid-level practitioners, and the development of advanced specialization for such personnel, have been advocated by the Commission in both its 1978 Plan and its current 1980 report

3. Numbers of enrollees in undergraduate and graduate medical education should be planned to reflect the numbers of physicians needed as determined by the Office of Statewide Health Planning and Development.

Rationale: Effective voluntary planning and successful incentive programs to effect a desirable geographical distribution and specialty balance may make it unnecessary for the State to consider regulatory measures to affect physician supply. Such planning should be based on need for physicians established by a State source.

4. The State should view direct regulation of physician numbers and practice location as a last resort for protecting the public's interest in an adequate but not excessive, supply of physicians

Rationale: An ever-increasing number of physicians entails significant economic consequences and creates a potential for provision of unnecessary Given the continued inmigration of physicians and the total physician population, it theoretically might be possible to meet the "number of physicians needed" without any medical education programs in California. However, as a planning agency concerned with educational opportunity, the Commission cannot accept a rationale for providing medical education based solely on manpower needs.

As noted in the rationale, voluntary actions coupled with incentives are the key to the problem of physician distribution. These measures would appear to include the continued recruiting of additional undergraduate and graduate students, who will receive information—and possibly incentives—for choosing a career path which is both personally gratifying and socially productive.

This recommendation is generally consistent with the Commission's position that cooperative and voluntary efforts should be used in working out problems of physician numbers and distribution. Relative to the effects of an "excessive" supply of physicians, health manpower planners should provide a balanced analysis of such effects, so that the public will clearly understand that limiting

care. If rationalized economic incentives fail to moderate growth . . ., more direct controls may be required.

5. The State should support the preparation of mid-level practitioners to assume appropriate roles in primary health care teams, and identify and employ all feasible methods to remove remaining barriers.

Rationale: Physicians' assistants, nurse practitioners, certified nurse midwives, and expanded duty dental auxiliaries have demonstrated that they effectively perform many health care tasks. Their acceptability by the public has been high, they have tended to locate in need areas, and work well in collaboration with their associated professionals. At the same time, attitudes, practice regulations, third-party reimbursement and other barriers continue to impede the maximum use of these health professionals. the number of physicians is in its own interest.

The Commission, in its 1978 and 1980 reports, has consistently endorsed the concept of stronger roles for midlevel practitioners, and the elimination of barriers to their full utilization.

6. Steps taken by the State, by schools of nursing, and by hospitals to improve the distribution of nurses should be directed toward changes in recruitment, training, and working conditions, rather than toward increases in overall supply.

This recommendation is consistent with the findings of the Commission in developing the nursing section of its 1978 Plan.

Rationale: The lack of nurses is due to problems "in the pipeline" following entry into school and practice. Additional numbers alone will not improve current, specific shortages.

7. Diligent recruitment of minority students into all the health professions, and strong support of minority health care practitioners who serve minority groups, should be a secure part of any state health personnel manpower program, particularly where numbers of places, positions, or reimbursements are to be held constant or diminished.

Rationale: The primary route for minority advancement in the health care professions has been through increasing the supply. Commitment to opportunity and rewards to minority students and practitioners must be maintained within overall, necessary, societal limits.

In all of its planning documents, the Commission has called for the recruitment and support of minority health professionals. At the same time, the Commission has pointed out a greater share of a fixed amount of educational opportunity for one group inevitably will mean less of the same opportunity for another.

 Legislation should be enacted to enable a gradual and rational integration of various personnel practice acts, state-recognized roles, and quality monitoring

Rationale: Legislation is necessary to achieve a full-scale, long-term rationalization of personnel resources consistent with related State policies concerning financing and organization of health services.

9. All health professions' education programs should incorporate processes for student selection and training such that those selected and trained are those most likely to practice actively and to work in locations where most needed.

Rationale: Many current problems of personnel maldistribution and unavailability can be traced to inadequate selection and training procedures. Selection and training should anticipate actual conditions of practice (some of which, of course, need to be changed) and reflect State health care policy.

 Planning methods used by the Office of Statewide Health Planning and DeThe Commission supports in principle the "rationalization of personnel resources," but feels that considerable discussion of this problem is necessary before the Legislature undertakes to identify and resolve the problem

This recommendation is consistent with the findings of the Commission in developing the nursing section of its 1978 Plan, and is applicable to all health professions

The Commission noted in its 1978 Plan that the present system of identifying health velopment and the Health Systems Agencies should integrate analyses and need projections among different types of manpower and between manpower and other health resources.

Rationale: Fragmented planning for particular types of manpower resources is not conducive to consideration of broad cost-effective approaches, alternatives, or trade-offs.

care needs is inflexible; it is geared to discrete categories of professionals and ratios of such professionals to the population, rather than to determining how the total needs can be met through the use of a number of different kinds of health professionals and paraprofessionals working together.

A related recommendation on health manpower appears in the section of the State Health Plan dealing with cost containment.

1. The benefits of existing health facility and personnel licensure and certication regulations should be evaluated, the benefits of future regulalations demonstrated, and redundant and duplicative regulations eliminated.

Rationale: The intent of licensure and certification regulations is generally to protect public safety and welfare. The impact on costs is not always considered. Under current conditions, such inattention cannot continue

The Commission believes that a study of personnel licensure and certification is an appropriate part of the "rationalization of personnel resources" called for in Recommendation 8 above

Several other recommendations from the <u>State Health Plan</u>, which are listed below, are of interest to the <u>Commission</u>, inasmuch as they suggest the need for a shift to preventive health care, a theme given further treatment in <u>Section Three</u> of this report.

Recommendation 1 on Coordination There should be an emphasis in State programs away from traditional medical services and toward promotion and prevention services, and state agencies should develop ways to shift resources to such programs.

Recommendation 4 on Costs
Major environmental interventions and personal responsibility for health should be recognized as necessary, long-term strategies for controlling health care costs.

Recommendation 5 on Prevention/Promotion
The Office of Statewide Health Planning and Development should establish a task force to develop planning approaches to promotion and prevention, including identification of supply resources, specification of target groups, and estimates of resource requirements.

Recommendation 7 on Prevention/Promotion
The Department of Health Services, in cooperation with
universities in the state system, the California Medical
Association, and the Department of Education, should
design K-12 curricula to emphasize health promotion and
disease prevention in health education programs.

Recommendation 9 on Prevention/Promotion Research should be undertaken to determine effective methods of encouraging personal health promotion, including transmission of information and sources of resistance to changing personal behavior.

Recommendation 10 on Prevention/Promotion Self-care should be viewed as the prerogative of an individual of any class, and the Health and Welfare Agency should seek ways to promote acceptance of self-care, but not as a substitute for needed or appropriate professional care.

Recommendation 11 on Prevention/Promotion
Health sciences (medical, nursing, etc.) schools and
professional associations should accord greater weight to
the potential of self-care in chronic disease management,
and should train students and practitioners to teach
patients to use self-care.

For the Commission's views on the prevention of disease and the promotion of health see the section of this report dealing with preventive health care, Part III

SECTION D: GERIATRIC NURSE PRACTITIONERS

Assembly Bill 2796 (Chapter 907, Statutes of 1978) directed the Commission to study certain aspects of professional education in the field of geriatric medicine. The Commission reported to the Legislature in January 1980 on all aspects of the study except the role of nurse practitioners and physician assistants in the provision of geriatric care. Inasmuch as the reporting date for that final section of the study was January 1981, the Commission has decided to combine its report on nurse practitioners and physician assistants in geriatric care with this 1980 report.

In its report on geriatric medicine the Commission made this observation:

It is quite possible that geriatric nursing rather than medicine is the key to improving the health care of the elderly. Inasmuch as nurses spend far more time with patients in long-term-care facilities than do physicians, they become the primary providers of chronic (sic) health care for the aged.

The Commission's 1978 Health Sciences Education Plan listed those training programs for nurse practitioners and physician assistants which had a particular focus. No physician assistant program was oriented toward geriatric care, and only the nurse practitioner program at California State University, Long Beach had a geriatric focus.

Since that time, four other programs have come into existence: two at the University of California, Los Angeles; another at the University's San Francisco Medical Center; and one at San Jose State University. One of the Los Angeles programs is a gerontological nurse practitioner option and gerontological clinical nurse option, both leading to an M.N. degree. The San Francisco program, which is offered primarily at the doctoral level, is in long-term care/gerontological nursing. At San Jose State University a new Gerontological Nurse Specialist program leads to the M.S. degree. Thus, while unique opportunities in geriatric health care seem to exist, particularly for nurse practitioners, relatively little attention has been devoted until recently to educating specialized personnel in this area.

One of the difficulties in establishing nurse practitioner programs in State institutions has been the lack of adequate funding. Some programs have had small enrollments which have not generated enough State support to offset high costs; others are certificate, rather than degree programs, thus earning enrollment-based financial

support at the highest--and least remunerative student/faculty ratio. The threatened reduction of federal support to health personnel programs, including reduced funding for special project grants, increases the fiscal difficulties being encountered today by nurse practitioner programs.

A related problem is that of administrative structure. Of the nine nurse practitioner programs in various fields identified in the 1978 Health Sciences Education Plan, only four reside in university nursing schools. Two are housed in public medical school settings, two in public hospital settings, and one at a State University campus which has no other nursing or allied health programs. Such arrangements militate against a program attaining strong institutional identity, prestige, and support. Fortunately, all the geriatric/gerontological nurse practitioner programs are housed in strong, well-established nursing schools or departments.

Two possible solutions to the funding problem seem readily apparent. One is to cluster a number of advanced nursing specialty programs in the same institution so that they can share expensive resources. This approach seems to have helped the San Francisco and Los Angeles campuses of the University and California State University at Long Beach, in developing stable nurse practitioner programs, including those in geriatrics/gerontology. The other solution is to adopt the subsidy approach used by the State to encourage the training of family nurse practitioners. A portion of the annual Song-Brown Act appropriation is set aside to assist family nurse practitioner programs. In 1979-80 about \$157,500 was awarded to such programs, with another \$262,500 going to physician assistant programs. If the State considers the training of geriatric nurse practitioners to be a high priority, similar subsidy program might be an effective way to increase the number of such personnel

In the final analysis, the potential effectiveness of geriatric nurse practitioners depends on the degree to which the State grants the statutory authorization to all nurse practitioners to exercise the independent judgments necessary to provide ongoing health care. The development of greater professional autonomy for nurse practitioners in California has been slow, a situation which may reflect problems of role identity more than adequate financial support

The inherent ambiguity in the nurse practitioner's role is reflected in language in the Business and Professions Code:

The Legislature finds that various and conflicting definitions of the nurse practitioner are being created by state agencies and private organizations within California. The Legislature also finds that the public is

harmed by conflicting usage of the title of nurse practitioner and lack of correspondence between use of the title and qualifications of the registered nurse using the title. Therefore, the Legislature finds the public interest served by determination of the legitimate use of the title "nurse practitioner" by registered nurses. [Section 2834.]

In response to this legislative mandate, efforts by the Board of Registered Nursing to reduce the ambiguity have not been entirely successful. Regulations issued by the Board in 1979 specify that nurses may identify themselves to the public as nurse practitioners if they have: (1) completed a program of study approved by the Board; (2) been certified by a national or state organization; or (3) completed a nonapproved program together with two years of experience in "primary health care." No educational level is specified, and associate degree, diploma, and baccalaureate nurses can all become nurse practitioners after the same two semesters of training in a curriculum with seventeen specified elements in an academic or hospital setting. Because of the looseness of the educational requirements under these regulations, the first Health Sciences Education Plan called for the State to take the additional step of certifying nurse practitioners at a standardized high level of educational attainment, provided that experiential pathways to such certification were also available. Legislation sponsored by the Department of Consumer Affairs (SB 666), contained a provision for certification of nurse practitioners, but failed passage in the Legislature early in 1980. 1/

Other factors continue to limit the utilization of nurse practitioners. Nurse practitioners cannot function at any level higher than that allowed to nurses under the Nurse Practice Act. They generally cannot prescribe treatment or medication, admit patients, or be reimbursed by third-party payers. Physician acceptance of nurse practitioners also remains a problem.

In spite of these limitations, however, there is still movement toward expanded roles for nurse practitioners in the care of the chronically ill. A widely-cited study in Utah has shown that geriatric nurse practitioners, social workers, clinical pharmacists, and physicians, are a particularly effective delivery team in providing quality primary health care in nursing homes. An important aspect of this team approach is the ability of the nurse practitioner to train the aides and other non-professional employees of nursing homes to deal with areas which would ordinarily require the attention of a nurse practitioner or physician.

Given the reluctance of physicians to spend great amounts of time on elderly patients with chronic conditions, as noted in the

Commission's report on geriatric medicine, the geriatric nurse practitioner appears to be the health professional best equipped to assume major--perhaps even basic--responsibility for the care of the chronically ill in institutional or home settings.

After an examination of the potential utilization of nurse practitioners in geniatric care, the Commission offers the following findings.

Findings

- 1. Several geriatric nurse practitioner programs and/or specialized nursing programs with geriatric or gerontological emphases operate within the State. These programs appear to be well-designed, and are housed in educational institutions which can supply the support necessary to insure quality and viability of programs. Nurse practitioner programs in other specialties could benefit from similar arrangements.
- Advanced nursing specialization requires advanced or postgraduate education. Therefore, there is need to explore the question of whether nurse practitionersincluding those with geriatric/gerontological specialization--should be educated at the baccalaureate level or equivalent as a minimum foundation for their advanced certificate or degree training.
- 3 Before optimum utilization of nurse practitioners in geriatric patient care can be achieved, legal and attitudinal barriers to the semi-autonomous practice of such health professionals must be overcome.

SECTION E: GENERAL AREAS OF CONCERN

In concluding the first section of this report, it is necessary to comment briefly on some concerns which remain from the Commission's 1978 report, or which have been identified in the development of this second report. One of the concerns involves medicine, and two, nursing. The remaining issue deals with the limitations in developing an informational base necessary for decision making in health manpower and health sciences education.

Graduate Medical Education

The size and the composition of the graduate medical education programs in California continue to present problems to manpower and educational planners.

For several years there has been pressure on the University of California, and to a lesser degree on private universities, to modify graduate medical education programs. This pressure has been exerted through recommendations in the Health Manpower Plan, through bills (largely unsuccessful) in the Legislature, and through supplementary budget language. The pressure generally has been applied to the existing distribution of primary and nonprimary care residencies, with calls for more residents in family medicine, general internal medicine, pediatrics, and OB-GYN, as well as in certain specialties perceived to be in short supply: emergency medicine, public health, occupational medicine, and preventive medicine. For all other specialties, medical schools have been called upon to reduce or hold constant their enrollments.

Until recently, compliance with these calls for change has been voluntary, but in the 1980-81 State Budget the Legislature imposed reductions in the number of non primary care residents in the University of California's medical schools. The Legislature also imposed on the University the requirement to develop a system whereby various State priorities are reflected in the creation of new residencies and in the shifting of residencies from location to location and specialty to specialty. The Commission believes that the University's response will be a significant step in improving planning for residencies. But it also believes that the task will be difficult for a number of reasons:

1. State policy on residencies is not clear. The State is committed through the Song-Brown Act to support family practice residencies, but not necessarily to the exclusion of others. The <u>Health Manpower Plan</u> calls for an emphasis on primary care residencies—and appendices to that Plan have

called for drastic reductions in other residencies--but the Plan has not been adopted by the Legislative or Executive Branch. The Legislature, but only through supplemental budget language in recent years, has called for increases in primary care residencies at the expense of others. For many years, however, the residency programs in California were allowed--even encouraged--to grow to their present proportions without policy guidance from the State, so it is not clear even today just what "public policy" is in this area

Furthermore, there are several recent developments that raise questions about the basic premises of State "policy" on residencies. A study published in 1979 by a group of researchers at the University of Southern California strongly suggests that considerable amounts of what is normally regarded as primary medical care are delivered by specialists. Thus, the assumption of State planners that providing more primary care, requires training more physicians in the primary care specialties may not be exclusively true. In addition, the long-awaited report of the Graduate Medical Education National Advisory Committee, issued just this fall, suggests that virtually all specialists will be in surplus by 1990, even those in primary care, including family physicians. This prediction suggests that the State should be thinking about cutting back on all residencies, not just non primary care

- 2. Some State concerns such as geographical maldistribution cannot be solved by approaches based on geography alone. The State may indicate that a particular area is medically underserved, but unless there are teaching or affiliated hospitals in the area at which residents can be trained, graduate medical education cannot be expected to support the State's goal of more medical care in the area.
- 3. Enrollments in graduate medical education programs in California is not the result of any specific University policy. Enrollments in graduate medical education exceed those in undergraduate medical education by a ratio of at least two to one. There are several explanations of this phenomenon:
 - a. California has a number of urban centers containing the kinds of large hospitals in which graduate medical education takes place. Some states, including several with medical schools, simply do not have the population or institutional base for this type of education.

- b. California provides graduate medical education for a large number of people who received their basic medical education in other states and countries. California remains an attractive place for graduate and/or professional education for those educated elsewhere.
- c. There are medical schools elsewhere in which the graduate medical education component is not as large as the undergraduate medical education component.
- d. California sponsors a share of the total United States effort in graduate medical education which is commensurate with its share of the population. The Journal of the American Medical Association notes that 9.6 percent of the 4,630 accredited residency programs in this country are in California (as of October 1979) and that 6,503 residents were being trained in California of the 63,163 being trained nationally (as of September 1978). These ratios compare closely to the approximately 10 percent of the United States population which is made up of Californians.
- e. Nationally, there are 71,573 residencies being offered during 1980-81, and there were 62,574 students enrolled in United States medical schools the previous year. This means that there are roughly 14.4 percent more residency slots than there are students in training (and the total length of the two types of training is roughly comparable). Since it is likely that virtually all new graduates of American medical schools will be going through formal residencies, the surplus of residency seats probably exists to accommodate foreign medical graduates and older physicians who are acquiring their first formal specialty training, or perhaps retraining in a new specialty. California may appear to have a disproportionate amount of this training, but even if the State has 6,503 residents, its share of the national residencies is only 9.1 percent. 2/

This detail has been presented in order to show that the question of what is an appropriate level of activity for the University of California in graduate medical education is a complex issue, involving a number of factors other than the State's supply of and demand for specialists.

Attrition in the Nursing Profession

The situation described in the 1978 <u>Health Sciences Education Plan</u>, with respect to the unwillingness of many nurses to work, has not improved.

An examination of help-wanted columns in the classified sections of metropolitan newspapers, and a review of the quarterly and annual reports of the California Hospital Association on the number of vacancies in nursing, should convince any reader that a problem of supply exists. Notwithstanding the existence of a large reservoir of trained nurses in California, large numbers do not choose to work under existing conditions. Regardless of whether it is called a shortage or a withholding of service, the problem of supply is real and it is getting worse. Curiously, it has not been linked by the media to any significant deterioration of health care in the State, although there is ample evidence of the closing of units—even wings—in hospitals for lack of nurses. There is ample evidence, too, that the resulting pressures on the nurses who do work in hospitals further contributes to dissatisfaction and defection.

The lack of dialogue on this situation is also a curious phenomenon. Neither the Legislature nor the Office of Statewide Health Planning and Development has expressed great concern about this problem, but the California Hospital Association—representing the employers of the majority of nurses in the State—has actively sought the support of other agencies, including the Legislature, in dealing with the nurse shortage. Educators have remained relatively silent on this issue as well, perhaps because the solution to the problem does not appear to lie within the nursing curriculum.

Progress in resolving the difficulty, however, is discernible, albeit dimly. Stories in the media have done much to identify the real issues underlying the widespread dissatisfaction with nursing as a career. Increasingly, bright young American women reject the notion that women in nursing must be docile, a quality which nursing recruiters are going overseas to find. With utter candor, the California Hospital Association states that the industry needs docile nurses, and those who are dependable and can follow directions. The nursing profession may resent this attitude, but it scarcely speaks with a single voice about what it is that nurses want.

Programs in Nurse-Midwifery

The administrative structure for programs to train nurse-midwives in California does not appear to be conducive to strong fiscal support and professional identity.

There are three nurse-midwifery programs in California: one at San Francisco General Hospital, sponsored by the OB-GYN Department of the Medical School of the University of California, San Francisco; one in the Department of Community Medicine in the Medical School of the University of California, San Diego; and one which will soon begin operation in the Department of OB-GYN in the Medical School of the University of Southern California.

The most unique program, administratively, is the one in San Francisco. A student wanting to enter this program registers through Continuing Education in Nursing at the University of California, San Francisco, paying a fee of \$2,000 for four quarters—almost double the normal fee structure for regularly enrolled students. A dilemma is at work here: The program was conceived philosophically to be open to all nurses—including those without the B.S. degree—and thus must operate at the certificate level. Because it is a certificate program, and incompatible with the San Francisco campus's academic mission in nursing, it cannot be offered as a regular component of nursing instruction at the normal fee level.

Under these circumstances it is remarkable that the program has survived at all, much less graduated its first class and achieved accreditation. Apparently no State higher education funds have supported the instruction in this program. Instead, federal funds-including some coming through the State Department of Health Services-have underwritten much of the start-up costs of the program. Enter another dilemma: the National Health Service Corps, the major supporter of nurse-midwifery students, refuses financial assistance to programs not on a graduate level. The possibility for stable financial support seems to elude the program at every turn.

At a reported annual cost of \$25,000 per student, midwifery training may require some special State support if it is to become a permanent part of health science instruction in the University of California. With a student/faculty ratio of eight to one, and with relatively small enrollments, it is clear that only a fraction of the cost of such instruction could be met through conventional enrollment-driven State support.

The nurse-midwifery program at the University of California, San Diego, has faced similar uncertainties in funding. It is a nurse-midwife component of a nurse practitioner program, housed in a medical school. It has also depended heavily on federal funding. It is a certificate program out of necessity, inasmuch as there is no nursing program at the San Diego campus, to provide academic ties, but it is designed as a post-baccalaureate program. It is now accredited, and currently has six students.

The program at the University of Southern California is ready to enroll its first students in January of 1981. It is a post-baccalaureate program, and there are plans to offer ultimately a master's degree, although the campus has no professional program in nursing at the present time. The nurse-midwifery program will begin with only four students, building to an enrollment of twelve. This program was conceived to operate without the "soft money" of federal grants, using instead regular university budget support.

Questions must inevitably be asked concerning these nurse-midwifery programs. Are they really needed? Can they ever become viable?

The Department of Health Services, which has subsidized the nurse-midwifery programs, argues that the programs are needed. At a recent legislative hearing on midwifery it was noted that seventeen counties of the State do not have an obstetrician, and midwives are needed in order to increase access to and lower the costs of prenatal, perinatal, and postnatal care. The option of using midwives was also identified as a consumer issue—a woman should be able to choose to have her baby delivered in other than the impersonal setting of a hospital delivery room by a physician whom she has seen previously only during a series of brief visits. At this hearing there seemed to be cautious acceptance of nurse—midwifery by physicians, but no comparable acceptance of lay midwifery.

As to the viability of nurse-midwifery programs, it is difficult to offer a prediction. The San Francisco program, in particular, requires attention from State planners. Some of its problems would end if it were moved to the postgraduate level, as is the case with the programs at the University of California, San Diego, and the University of Southern California, rather than kept at the certificate level. In determining how to resolve the special problems of the program at San Francisco, it might be useful if the Legislature and interested agencies could explore the entire question of nurse-midwifery without discussing lay-midwifery, a subject which seems to raise other and often emotional issues.

Information Needs for Health Sciences Planning

The research and information capabilities of the State and its institutions have not been utilized extensively enough in providing information to aid in making public policy decisions in health manpower and health sciences education.

The Commission senses that future health sciences education plans will require much better information than that which has characterized its first two plans. Improvements in information are necessary not only in descriptive data about students who are being

educated in the health sciences in California, but also in the basic information that shapes the assumptions under which the State operates.

To be specific, imbalances in health manpower today are largely those of maldistribution, rather than of shortage. In the case of physicians, this maldistribution can be either geographic or by specialty, or in the case of nurses, by willingness to work. Manpower planners--and educational planners, anxious to show that the educational system is concerned with relevancy, profess to understand the supply and demand economics and the incentive systems which presumably lead the health professional to practice in an area where he or she is needed. But the information which underlies the basic assumptions of the planners may be fragmentary, out-of-date, or from geographical or cultural settings unlike California example, planners assume from a review of the literature that factors such as place of origin and location of residency training influence the location of practice site for a physician. But what do planners really know of this relationship in California in recent years in the various geographical settings? The absence of applicable research on this question raises doubts about assumptions concerning the factors related to choice of practice site, and yet public policy-including a State-supported subsidy program--is based on this assumption.

Planners also assume that an excessive supply of medical specialists is socially undesirable because health economists have argued that it is, but for the most part that assumption has not been tested in California--particularly in light of the recent study at the University of Southern California that determined that specialists provide considerably more primary health care than was once thought to be the case.

Similarly, planners profess to understand some of the reasons why nurses drop out of active employment in such large numbers. But in California there is yet not enough research that identifies the real reasons why nurses are reluctant to work, even though tens of millions of dollars are being spent annually on band-aid approaches in trying to fill vacant nursing positions.

The research capability to deal with these problems constructively is scarcely lacking in California. California probably has one of the most highly developed research capabilities of any state, including its universities and their organized research institutes, its faculties and graduate students, its private think-tanks such as the Rand Corporation, and its various State agencies in health manpower and planning, health services, educational coordination, and legislative research. What is lacking is a means of coordinating the efforts of all these groups to insure that the basic information

needs of health planners and policy makers in Sacramento can be communicated to and ultimately met by some appropriate element of the research establishment.

During the time this report was being prepared a document was published that could have a significant effect on residencies in the United States, and perhaps on undergraduate medical education as well. After a three-year study, the Graduate Medical Education National Advisory Committee published its report on specialty training in medicine. At the request of the federal government, this distinguished panel has developed a number of recommendations, some of which suggest significant reductions and shifts of emphasis in graduate and undergraduate medical education. Because of the recency of this report, there has been no attempt to examine it here, but the main recommendations of the report—as described in the Chronicle of Higher Education—are contained in the Appendix.

FOOTNOTES

- It might be possible to achieve the goal of establishing higher educational standards for nurses who specialize in the care of the elderly by identifying their activities with the public health nurse, rather than with the nurse practitioner or clinical specialist. Public health nurses are certified by the Department of Health Services which requires that they be graduates of baccalaureate nursing programs. A new pilot program established by AB 3122 (Moorhead) of 1980 authorizes the use of equivalent experience in lieu of the degree. Perhaps advanced geriatric nursing could benefit from establishing such educational or equivalency requirements for certification. It is interesting to consider the benefits of a public health nurse functioning as a gerontological specialist, visiting nursing homes regularly to check on the health care needs of older patients.
- The exact number of residencies in California has been difficult The 1978 Health Sciences Education Plan, using to determine materials developed in a survey by the Office of Statewide Health Planning and Development, placed the figure at 8,799 non-federal and 741 federal residencies. However, the list of California residencies in that edition of the Plan, taken from the directory of accredited residencies published by the Liaison Committee on Graduate Medical Education, included 6,813 non-federal and 767 federal positions. In a supplement to the 1977 Health Manpower Plan, the Office of Statewide Health Planning and Development revised the figure for non-federal residencies to 8,058. A new study by that agency, based largely on American Medical Association data and released at the end of 1980, places the nonfederal figure at 6,510 for 1980-81, excluding flexible residencies. The California Postsecondary Education Commission acknowledges that its concerns about the growth in residencies in recent years have been influenced by the higher totals in the earlier reports. Now, assuming that the total number of nonfederal residencies in California is closer to 6,500 than to 8,500--with roughly 4,200 affiliated with the University of California, 1,500 with independent medical schools, and the balance unaffiliated--there seems to be considerably less reason for concern about the growth of residencies than was suggested by the earlier totals

PART II

ALLIED HEALTH

INTRODUCTION

For the layman and the professional alike, allied health is the many-headed Hydra of the health care system. In no single area is the enormous growth of the health industry so apparent as in the allied health field. More than 100 allied health occupations and specialties 1/ and over 700 job titles now exist 2/ By 1978, it was estimated by the then U.S. Department of Health, Education, and Welfare (HEW) that more than 3.5 million workers nationally were employed as allied health workers; if one includes the occupations embraced by this Plan's working definition of allied health (see below), the number would be closer to 4 million. Yet, new specialties continue to multiply and educational programs to prepare individuals for both new and old health occupations abound. It is clear that the Hydra of allied health needs some sort of herculean effort to describe and perhaps to contain it.

DEFINITIONS

The term "allied health" itself is not easily defined. If described broadly, the field would include all professional, technical, and supportive workers in patient care and administrative services, health research, and health education. A recent federal report on allied health, however, excludes all physicians, dentists, optometrists, podiatrists, nurses, pharmacists, veterinarians, and other independent health practitioners as well as professional public health personnel, biomedical research personnel, natural and social scientists working in the health field, nursing auxiliaries, and occupations requiring no formal training. 3/

The American Medical Association (AMA) Council on Medical Education suggests that allied health personnel include professional and supporting workers in the fields of patient care, public health, and health research who assist independent practitioners in providing health services. 4/ The AMA's emphasis in this definition on the "independent practitioner" is vaguely reminiscent of the medical profession's earlier insistence on retaining the term "medical profession" for itself alone. This single-mindedness eventually brought the term "health professions" into use as an umbrella category. From there, it was a short step to "allied health professions" to indicate many diverse practitioners with different educational backgrounds, skills, and functions, working together to serve the patient or client. 5/

The Public Health Service Act similarly defines allied health personnel as all individuals with training and responsibilities for (a) supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (b) assisting environmental engineers and other personnel in environmental health control and preventive medicine activities. 6/ On the other hand, the National Commission on Allied Health Education endorses a more autonomous stance for allied health personnel as "all health personnel working toward the common goal of providing the best possible services in patient care and health promotion." 7/

Yet another definition for allied health personnel is that recently proposed by the Health Subcommittee of the U.S. Senate's Labor and Human Resources Committee:

The term Allied Health Personnel means individuals trained at the associate, baccalaureate, master's or doctoral level in a health-care related science, with responsibility for the delivery of health-care related services (included services related to the identification, evaluation, rehabilitation, and prevention of diseases and disorders, dietary and nutrition services, health promotion, and health systems management), but who, for the purposes of this title, are not graduates of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, or nursing 8/

In the interest of both clarity and comprehensiveness, this report will look at allied health in the broadest context possible and will exclude only those categories of health professions treated separately in the first section of this report medicine, nursing, dentistry, pharmacy, optometry, osteopathy, and podiatry.

BACKGROUND

At the turn of the century, health services were provided almost entirely in homes and doctors' offices, and physicians, nurses, and dentists constituted the health care team. Although other health-related professions gradually arose to augment the more established medical cadre—at least twenty—seven such occupations were established between the turn of the century and $1940 \ 9/$ —it was not until after World War II that the allied health work force exploded upon the health scene. Several reasons account for this phenomenal growth:

public demands for more health services

- rapidly changing technology in the health sciences
- . manpower shortages in the medical field
- . societal pressures for lower cost health care

As the nation's population continues to grow as a result of increased life expectancy, lower infant mortality, control and elimination of disease, and expanded public health education, it is anticipated that the allied health field will continue to expand and that the number of specialized allied health occupations will continue to proliferate.

A look at the want ads of any major metropolitan newspaper reveals the extraordinary range of allied health positions available. These allied health personnel apparently share only a commitment to the health field, for they are clearly differentiated by educational preparation, certification requirements, licensure qualifications, association membership, job functions, and the facilities where they may be employed. An allied health worker could be an eighteen-yearold medical assistant with a high school education who has been trained for 6-8 months in a small proprietary school and is now working under considerable supervision at a set of routine tasks in a physician's office, or a medical technologist with a baccalaureate degree and advanced clinical training in immunohematology who works independently in a large hospital laboratory, relying primarily upon his or her own critical judgment and expertise. Obviously, there is little reason for these two people to share any mutual feeling of professional kinship as members of the allied health field

Fragmentation, then, has accompanied growth. Each specialty and subspecialty is endowed with what has been called the "identity of one" 10/ syndrome leading to an "impotence of singularity." 11/ Students are schooled in the techniques of their field with little understanding of other disciplines. There is a tendency on the part of independent practitioners, like physicians, to share only the most routine tasks with their non-physician colleagues. Licensing laws and professional organizations jealously guard boundaries. The dangers of provincialism face every profession, and allied health is no exception. When differences are stressed rather than sımılarıtıes, vision constricts and unnecessary duplication multiplies. Edmund Pellegrino, often quoted spokesman for the health professions, accurately summarizes the situation:

Let us admit unequivocally that allied health personnel are absolutely essential in providing the complex technical services modern medicine entails. The question is not one of returning to some pristine simplicity which would obviate their use. Instead, the real issue is how to bring about some convergence in function and numbers. The present

course of unguided proliferation is socially untenable and fiscally unsupportable. $\underline{12}/$

Convergence, integration, and coordination are called for. The question is how to begin?

TAXONOMY

Because this report treats the educational needs of the allied health professional, an attempt has been made to circumscribe the dimensions of the allied health field by developing the following taxonomy which places occupational titles under broad functional areas. Any classification system has its limitations, however, and this is not the first attempt made to bring order to the allied health field. 13/ In using this or any other typology, several caveats are in order. First, discrete categories simply do not exist in allied health. Second, categorical boxes can lead to a larger "Pandora's Box" of problems. Sensitivities can be aroused and strong disagreements arise which may cast doubt upon the validity of the basic research effort. In addition, lines between categories are often blurred, and many occupations cut across several functions. For example, a dental hygienist can be labeled as fulfilling a preventive, diagnostic, therapeutic, and educational function. Based on the literature, this report would have the dental hygienist in the preventive category as that is most commonly seen as the primary function of the position. Yet, there assuredly would be disagreement from sources both within and without the profession. In addition, since the system to collect information about the allied health professions is imperfect, no generalizations can be made which is perhaps the most resounding caveat of all.

It is clear why there is no universally accepted allied health taxonomy. Everyone looks at allied health from varying perspectives. For the purposes of this report, however, a single taxonomy is requisite to an understanding of the profession and its educational needs. A classification system such as that displayed in Table AH-1 may also contribute to the coordination and integration of the allied health field. This section of the report should be viewed, therefore, as a beginning rather than as a conclusion.

TABLE AH-1

A Functional Taxonomy of Allied Health Fields

I. PREVENTIVE CARE

Dental Hygienist
Environmental Health Technician
Health Educator
Genetic Counselor
Industrial Hygienist and Safety Specialist
Nutritionist
Sanitarian

II. CLINICAL SERVICES

A. Diagnosis

Audiologist Bioanalyst Biochemist Biochemistry Technologist Clinical Laboratory Technologist Clinical Laboratory Bioanalyst Clinical Laboratory Microbiologist Cytotechnologist Electrocardiograph Technician Electroencephalograph Technician Hematology Technician Histologic Technician Nuclear Medicine Technologist Ophthalmic Technician/Assistant Radiologic Technologist, diagnostic Sonographic Technician Toxicologist

B. Medical-Surgical Care

1. Autonomous Practitioner

Chiropractor Naturopathic Physician

2. Paraprofessional

Blood Bank Technologist
Cardiopulmonary Technician
Cardiovascular Technologist
Dental Assistant
Emergency Medical Technician
Hemodialysis Technician
Home Health Aide
Hospital Pharmacy Technician
Medical Assistant (Office)
Midwife
Nursing Assistant/Aide
Psychiatric Technician
Surgical Technician

C. Rehabilitative Care

1. Therapeutic Care

Acupuncturist Art Therapist Clinical Social Worker Clinical Psychologist Dance Therapist Dietician Dietetic Technician Drama Therapist Herbalist Hypnotist Massage Therapist Music Therapist Occupational Therapist Physical Therapist Radiologic Technologist, Therapeutic Sex Therapist Recreation Therapist Respiratory Therapist Speech Pathologist Ultrasound Therapist

2. Restorative/Prosthetic Care

Dental Technologist
Denturist
Hearing Aid Dispenser
Optical Technician
Optician

Orthotist/Prosthetist

III. ADMINISTRATIVE SERVICES

A. Executive

Health Planner Health Service Administrator Hospital Administrator Nursing Home Administrator

B. Support

Biomedical Equipment Technician Medical Records Administrator/Technician Medical Statistician Medical Writer/Illustrator

IV. RESEARCH AND DEVELOPMENT

Biomedical Engineer Biomedical Scientist Geneticist

V. OTHER

It is clear that this listing of occupations is not exhaustive. Several hundred allied health fields can be named, but in such an extensive list, considerable duplication would be inevitable. For example, inhalation therapy, respiratory therapy, and pulmonary technology appear to be the same field; similarly, although there may be technical distinctions, an ambulance attendant, an emergency medical technician, and a paramedic are all involved in emergency care. The latter example illustrates a broad caveat that must be kept in mind in dealing with the allied health fields. educational programs, types of work performed, job titles, and categories of licensure frequently do not match up for allied health personnel as exactly as they do for physicians, dentists, nurses, optometrists, pharmacists, osteopaths, or podiatrists

Public health is a classic example of the disparity which may occur within a profession. There are a variety of educational programs in this field, leading to degrees in public health, including the M.P.H. and D.P.H., in schools of public health. There is a generic category of work performed which is known as public health, but no job titles

or licensure as public health workers or specialists exist. Public health becomes an adjective, describing the setting in which one carries out more specific work: public health statistician, public health nurse, public health epidemiologist, etc.

LICENSURE

In California, public health nurses and public health microbiologists are licensed by the State, as are personnel in many other allied health fields. In actual practice, this licensure is regarded as certification, since a person is not required to have it before practicing, but in this report all such State credentialing will be identified as licensure to distinguish it from the professional certification granted by private associations, an important form of competence assessment in the health professions.

The responsibility for licensure in the allied health fields is divided in California, with the Department of Consumer Affairs licensing some categories and the Department of Health Services licensing others. Some misalignment of educational programs and licensure occurs, as when environmental health sciences programs lead to licensure as a registered sanitarian. It is also difficult to identify some educational programs as the direct source of allied health personnel. For example, graduates in biology, chemistry, or microbiology may choose to pursue a career in a field other than allied health.

Table AH-2 indicates for various categories of allied health, as identified in the taxonomy of Table AH-1, the appropriate licensing and credentialing agency, if appropriate, and the location of the educational programs which appear to prepare students for the practice of the specialty. The primary source for Table AH-2 is the Inventory of Academic and Occupational Programs, to be found as Part B in the <u>Guide to California Colleges and Universities published by the Commission in August 1980. The information in this <u>Guide</u> is furnished by either the institutions themselves or by the <u>segmental</u> offices.</u>

TABLE AH-2

ALLIED HEALTH OCCUPATIONS, BY CREDENTIALS AND EDUCATIONAL PROGRAMS

Educational Proqrams	Independent Institutions College of Notre Dame U.S. International Univ.	University of California Santa Barbara California State Univ. and Coll. Chico Fresno Fresno Fullerton Hayward Humboldt Long Beach Los Angeles Northridge Sacramento San Diego San Francisco San Jose Stanislaus
Certification		American Speech and Hearing Association
<u>Licensure</u> Board of Medical Quality Assurance		Board of Medical Quality Assurance
Occupation Acupuncturist	Art Therapist	Audiologist/Speech

on Educational Programs	Independent Institutions Chapman Loma Linda Pacific Union Stanford La Verne Pacific	University of California Berkeley Davis Irvine Los Angeles Riverside San Diego San Francisco Santa Barbara California State Univ and Coll. Bakersfield Dominguez Hills Fullerton Hayward Long Beach Los Angeles San Francisco San Jose San Luis Obispo
Certification		
Licensure		Department of Health Services (Bloanalyst or Clinical Chemist)
Occupation	Audiologist/Speech Pathologist (Continued)	Blochemist -06-

Educational Programs	Independent Institutions	Loma Linda Mt. St. Marys Occidental Pacific Union Stanford	University of California Berkeley Davis Los Angeles San Diego	Santa barbara California State Univ. and Col	Long Beach Sacramento	Independent Institutions	Southern California	Community Colleges	Chabot College of the Desert Foothill Golden West Grossmont
Certification			Association for the Advancement of Medical Instrumen- tation						
Licensure									
Occupation	Blochemist (Continued)		Blomedical Engineer	1_				Biomedical Engineering Technician	

Occupation	Licensure	Certification	Educational Programs
Biomedical Engineering Technician (Continued)			Community Colleges (Cont.)
			Los Angeles City Los Angeles Trade/Technical Los Angeles Valley Monterey Napa Orange Coast
Blood Bank Technologist		American Association of Blood Banks	University of California Berkeley Davis
2-			San Francisco
Cardiac Care Tech-			Community Colleges
			Grossmont Mt. San Antonio
Clinical Laboratory Technologist (See Medical Lab- oratory Technolo- gist)	Department of Health Services		
Clinıcal Psychologıst	Board of Medical		California State Univ. and Coll.
	quaiity assulante		Dominguez Hills

Occupation	Licensure	Certification	Educational Programs
Clinical Psychologist (Continued)	Psychological Exam- ining Committee		Calif State Univ. and Coll. (Cont.) Fresno Fullerton Hayward Long Beach San Bernardino San Francisco San Jose Stanislaus Independent Institutions California School of Professional Psychology-Fresno Fuller Theological Seminary Graduate School of Human Behavior Institute for Integrative Therapy Pacific Graduate School of Psychology Palo Alto School of Professional Psychology Psychology Psychology Psychology Psychological Studies Institute Synthesis Graduate School for the
			Study of Man The Fielding Institute
Clinical Social Worker	Board of Behav- ioral Science Examiners		University of California Los Angeles

Educational Programs	California State Univ. and Coll. San Diego	San Francisco <u>Inde</u> pendent Institutions	Institute of Clinical Social Work	Independent Institutions	Cleveland Chiropractic LA College of Chiropractic	Pasadena College of Chiropractic Northern California Chiropractic	of University of California	San Francisco	Occupational Programs	Hospital of the Good Samaritan School of Cytology Mary Summerlin Hippen School of Cytology Los Angeles County-USC Medical Center Sharp Memorial Hospital
Certification							American Society of			
Licensure				Board of Chiro- practic Examiners			Department of Health Services			
Occupation	Clinical Social Worker (Continued)			Chiropractor		-94-	Cytotechnologist			

Educational Programs	Independent Institutions	Loma Linda	Community Colleges	Alameda	Allan Hancock	Bakersfield Cabrillo	Cerritos	Chabot	Chaffey	Citrus	City College of San Francisco	Cypress	Diablo Valley	Foothill	Grossmont	Los Angeles City	Long Beach	Marin	Merced	Modesto	Monterey Peninsula	Orange Coast	Palomar	Pasadena	Redwoods	Reedley	Rio Hondo	Sacramento	San Diego Evening
Certification	American Dental	ation																											
Licensure	Board of Dental Examiners																												

Dental Assistant

Occupation

Educational Programs
Certification
Licensure
Occupation

Dental Assistant (Continued)

Community Colleges (Cont.)

San Diego Mesa San Jose

San Mateo

Santa Barbara Santa Rosa

Occupational Programs (Degree-Granting Authorized)

Oakland College of Dental/Med-Bay Cities College of Dental/ Medical Asst.

ical Asst.

Rancho Arroyo College San Jose Institute of Paramedical Careers

Occupational Programs

Weslyn College of Medical and Dental Careers Western College of Allied Health Careers

Valley College of Medical/Dental Western College of Medical and Dental Assistants

United Health Careers Institute Careers

Southern California College of Medical and Dental Careers

Southland College of Medical-Dental-Legal Careers (4 locations)

<u>Occupation</u>	Licensure	Certification	Educational Programs
Dental Assistant (Continued) -6-			Occupational Programs (Cont.) Pacific College of Medical and Dental Assistants North American Correspondence School Mid-State College Lawton School for Medical and Dental Assistants (2 locations) Galen College of Medical and Dental Asst. (2 locations) Glendale College of Medical and Dental Asst. (2 locations) Glendale College of Worsiness Paramedical Eden Area Vocational Programs Bryman School (9 locations) Andon College of Vocational Health Careers The Barton School Med-Help Training School (2 locations) San Joaquin Valley College Valley Vocational Center Paramedical Occupations Center California Institute of Dental Technology San Diego College of Medical and Dental Assistants North-West College of Medical and
Dental Hygıenıst	Board of Dental Examiners		University of California San Francisco

Educational Programs
Certification
Licensure
Occupation

Dental Hygienist (Continued)

Independent Institutions

Loma Linda Southern California

Community Colleges

Cabrillo Cerritos Chabot Cypress Diablo Valley Foothill Fresno Pasadena Sacramento

West Los Angeles

Community Colleges

Board of Dental

Dental Laboratory Tech-

nologist

Examiners

City College of San Francisco Cypress Diablo Valley Merced Pasadena Riverside Santa Ana Occupational Programs (Degree-Granting Authorized)

Bay Cities College of Dental/ Medical Asst.

Educational Programs
Certification
Licensure
Occupation

Dental Laboratory Technologist (Continued)

Occupational Programs (Degree-Granting Authorized) (Cont.) Oakland College of Dental/Med-

ical Asst.

San Jose Institute of Paramedical Rancho Arroyo College Careers

Occupational Programs

California School of Dental Tech-Dental Technology Institute

Ultratex School of Dental Technology Weslyn College of Medical and Dental Careers

Medical and Dental Careers Southland College of Medical-Dentalnology Southern California College of

California Institute of Dental Legal Careers Technology

Denturist

Dietician (see Nutritionist)

Educational Proqrams	Community Colleges	Chaffey City College of San Francisco Grossmont Los Angeles Valley Long Beach Mission	Community Colleges	Mt. San Antonio Orange Coast Rio Hondo	Occupational Programs (Degree- Granting Authorized)	Bay Cities College of Dental/ Medical Asst. San Jose Institute of Paramedical Careers	Occupational Programs	Med-Help Training School California Paramedical and Tech- nical College Technical Health Careers
Certification				American Board of	registration of EEG Technologists			
Licensure								

Electro-Diagnostic
Technologist
Electrocardiography (EKG)
Electroencephalography (EEG)

Drama Therapist

Dietetic Technologist

Educational Programs	
Certification	
Licensure	
Occupation	

Emergency Medical Technician

Community Colleges

Allan Hancock Antelope Valley Bakersfield

Butte Chabot

Chaffey Compton

Crafton Hills Cuesta

Desert East Los Angeles Evergreen Valley

Evergreen val Gavilan Glendale

Imperial Valley
Los Angeles Pierce
Long Beach
Modesto
Mt. San Antonio

Ohlone Orange Coast Porterville

rorcerville Riverside Saddleback San Joaquin Delta

San Joaquin i San Jose Santa Ana Santa Monica Santa Rosa

Santa Ross Sequolas Shasta

Sierra Siskiyous

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Educational Programs
Certification
Licensure
Occupation

Emergency Medical Technician (Continued)

Community Colleges (Cont.)

Victor Valley Southwestern Skyline Yuba Occupational Programs (Degree-Granting Authorized) Bay Cities College of Dental/ Medical Asst.

San Jose Institute of Paramedical Careers

Occupational Programs

United Health Careers Institute American College of Paramedical Arts and Sciences

Southland College of Medical-Dental-Associated Technical College Legal Careers

Western College of Medical and Dental Assistants

Southern California College of Medical and Dental Careers

University of California

Geneticist

Berkeley Davis

Irvine

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Educational Programs	University of California (Cont.)	Riverside San Diego San Francisco	California State Univ. and Coll.	San Diego	Independent Institutions	Stanford	University of California	Berkeley	Univeristy of California	Los Angeles	California State Univ. and Coll	Los Angeles	Northridge	Sacramento	San Francisco	San Jose	oan turs onispo
Certification																	
Licensure																	
Occupation	Geneticist (Continued)						 Genetic Counselor	-	Health Educator								

Community Colleges

Los Angeles Valley Palomar

Occupation	Licensure	Certification	Educational Programs
Hearing Ald Dispenser	Board of Medical Quality Assurance		
Hematologic Technician			
Hemodialysis Technician			
Herbalıst			
Histologic Technician		American Society of Clinical Pathologists	
ا Home Health Aide			Community Colleges
			Antelope Valley Evergreen Valley Mission Mt. San Antonio
			Orange Coast Palomar Saddleback San Francisco Community Ce Shasta Victor Valley
			BOST

Educational Programs	University of California	Berkeley Los Angeles San Francisco	California State Univ. and Coll.	Bakersfield Chico Consortium Dominguez Hills	Fresno Los Angeles Northridge	Independent Institutions	Loma Linda Mt. St. Marys Stanford	Community Colleges	Cerritos Chahot	Cypress	Santa Ana	California State Univ. and Coll.	Hayward
Certification													
Licensure													
Occupation	Hospital Administrator				106	.—		Hospital Pharmacy Technician				Industrial Hygienist	Safety and Health Technologist)

Educational Programs Certification Licensure Occupation

Industrial Hygienist (Continued)

Independent Institutions

National Cogswell

Community Colleges

Los Angeles City Mt. San Antonio San Diego Cıty Orange Coast Chaffey Merritt Modesto

Occupational Programs

American Institute of Massage and Buena School of Massage Therapy

Getting in Touch School of Massage Massage School of Santa Monica Mueller College of Massage Sacramento Holistic Health Dean Associates at San Andreas Health Council

Institute

Massage Therapist

(see Respiratory Therapist)

Occupation	Licensure	Certification	Educational Programs
Medical Assistant	Board of Medical Quality Assurance and Department of	American Associ- ation of Medical Assistants; Ameri-	Independent Institutions Loma Linda
	Health Services (for certain pro-	can Medical Tech- nologists	Community Colleges
	(6)		Alameda
			Allan Hancock
			Bakersfield
			Certicos
			Chaffev
			Citrus
			City College of San Francisco
			Contra Costa
108			Cosumnes River
8-			Cuesta
			Cypress
			De Anza
			Desert
			East Los Angeles
			El Camino
			Indian Valley
			Los Angeles Cıty
			Los Angeles Valley
			Long Beach
			Modesto
			Monterey Peninsula
			Ohlone
			Orange Coast
			Palomar
			Pasadena
			Redwoods
			Rıo Hondo

Educational Programs
Certification
Licensure
Occupation

Medical Assistant (Continued)

Community Colleges (Cont.)

Riverside

Saddleback

San Bernardino

San Diego Evening

San Diego Mesa

San Mateo

Santa Ana

Santa Barbara

Santa Rosa

Shasta

West Valley

Occupational Programs (Degree-Granting Authorized)

Bay Cities College of Dental/ Medical Asst.

Oakland College of Dental/Medical Asst.

Rancho Arroyo College San Jose Institute of Paramedic Careers

Occupational Programs

Bryman School (9 locations)
CCDS Community Skill Center
Paramedical Occupations Center
The Barton School
Med-Help Training
San Joaquin Valley College

Educational Programs
Certification
Licensure
Occupation

Medical Assistant (Continued)

Occupational Programs (Cont.)

Weslyn College of Medical and Dental Careers Western College of Allied Health

Careers

Western College of Medical and Dental Assistants Valley College of Medical/Dental

Careers

United Health Careers Institute Southern California College of

Southland College of Medical-Dental-Legal Careers (4 locations) Medical and Dental Careers

Pacific College of Medical and Dental Assts.

North American Correspondence School North-West College of Medical and Dental Assts. (2 locations) Medical Training Institute

Mid-State College

Lawton Institute of Medical Studies Lawton School for Medical and

Dental Assts. (2 locations) HMO Research Institute

Hillcrest College

Galen College of Medical and

Glendale College of Paramedicals Dental Assts. (2 locations)

Cabrillo School of Nursing California Paramedical and Tech-

nıcal College

Occupation	Licensure	Certification	Educational Programs
Medical Assistant (Continued)			Occupational Programs (Cont.) Andon College Vocational Health Careers MTD Business College Institute of Medical Studies Associated Technical College California Pacific College/Institute of Medical Studies San Diego College of Medical and Dental Assistants Eaton College Maric College
Medical Laboratory Technologist	Department of Health Services	American Society of Clinical Patholo- gists	California State Univ. and Coll. Bakersfield Chico Dominguez Hills Fullerton Hayward Humboldt Long Beach Los Angeles Northridge Pomona Sacramento San Francisco San Jose San Luis Obispo Sonoma

Certification	
Licensure	
Occupation	

Medical Laboratory Technologist (Continued)

Independent Institutions

Educational Programs

Callfornia Lutheran College of Notre Dame

Holy Names

Loma Linda Pacific Union Community Colleges

Chabot

Desert Fullerton Laney San Diego Mesa

Ventura

Occupational Programs (Degree-Granting Authorized)

Bay Cities College of Dental and Medical Asst.

Oakland College of Dental and Medical Asst.
San Jose Institute of Paramedical

Occupational Programs

Careers

More than 50 hospitals offer the one-year clinical training required for licensure in laboratory technology.

Educational Programs	University of California Los Angeles	Independent Institutions Loma Linda	Community Colleges	Cerritos Chabot City College of San Francisco Crafton Hills	Cypress East Los Angeles Fresno	San Diego Evening San Diego Mesa West Valley	Occupational Programs (Degree- Granting Authorized)	Bay Cities College of Dental and Medical Asst.	Occupational Programs	Weslyn College of Medical and Dental Careers West Valley Occupational Center Grossmont School District Health Careers Center Galen College of Medical and Dental Assts
Certification	American Medical Records Association		American Medical Records Association							
Licensure										

Medical Records Technıcian

Medical Records Administrator/Librarian

Educational Programs
Certífication
Licensure
Occupation

Nursing Assistant/Aide (Continued)

Community Colleges (Cont.)

Cuesta Citrus

Imperial Valley

Long Beach Marin

Merced

Merritt

Mission

Porterville Modesto

Saddleback Redwoods

San Francisco Community Center Santa Monica Shasta

Victor Valley Southwestern

Occupational Programs (Degree-Granting Authorized)

Rancho Arroyo College San Jose Institute of Paramedical Bay Cities College of Dental and Medical Asst.

Careers

Occupational Programs

Medical Services Training Center HMO Research Institute

Occupation	Licensure	Certification	Educational Programs
Nursing Assistant/Alde (Continued)			Occupational Programs (Cont.) Harbor Occupational Center Hilldale Vocational School Grossmont School District Health Careers Center Cabrillo School of Nursing California Pacific College Palo Vista College of Nursing and Allied Health CCDS Community Skill Center Valley Vocational Center Paramedical Occupational Center West Valley Occupational Center
Nursing Home Admin- istrator	Board of Examiners of Nursing Home Administrators		
Nutritionist			University of California Davis
			California State Univ. and Coll.
			Chico Fresno Long Beach Los Angeles Northridge

<u>Licensure</u> Certification Educational Programs	Calif. State Univ. and Coll. (Cont.)	San Diego San Jose San Luis Obíspo	Independent Institutions	Chapman College of Notre Dame Loma Linda Pacific Union Whither	Community Colleges	American River	Bakersfield Butte	Canada	Chabot	City College of San Francisco	Compton Fullerton	Hartnell	Los Angeles Harbor	Lassen	Long Beach
Occupation	Nutritionist (Continued)														

Merritt Moorpark Mt. San Antonio Orange Coast

Certification Educational Programs	Community Colleges (Cont.)	Pasadena Riverside San Bernardino San Joaquin Delta Santa Ana Santa Rosa Ventura	American Occupa- California State Univ.	cional inerapy Association San Jose	Independent Institutions	Loma Linda Southern California	Community Colleges	Chabot Fullerton Los Angeles City Monterey Peninsula	Community Colleges	Canada
Licensure										
	(Continued)		Therapist						chnologist	
Occupation	Nutritionist (Continued)		Occupational	-11	8-				Ophthalmic Technologist	

<u>Occupation</u>	Licensure	Certification	Educational Programs
Ophthalmıc Technologıst (Continued)			Community Colleges (Cont.) Citrus Crafton Hills
			San Diego City
Optician, Dispensing	Board of Medical Quality Assurance		
Optical Technician			Community Colleges
-119-			Crafton Hills Los Angeles City Santa Rosa
			Occupational Programs
			Delco College of Optics Valley College of Medical and Dental Assts. American College of Optics
Optometric Technologist			Independent Institutions
			Southern California College of Optometry
			Community Colleges
			Cypress

<u>Licensure</u> Certification	۵ د د د د د د د د د د د د د د د د د د د	Board of Medical	Quality Assurance			»t	
<u>Occupation</u>	Orthotist/Prosthetist	Physical Therapist				Physical Therapy Asst	

Certification Educational Programs	Community Colleges (Cont.)	Mt. San Antonio San Diego Mesa Ventura	Occupational Programs	Cobb Method Self-Employment Center	censed Community Colleges		Exam-	Cypress	East Los Angeles Golden West	Los Angeles Trade-Technical	Mission	Mt. San Antonio	Napa	Porterville	R10 Hondo	Saddleback	San Bernardıno	San Francisco Community Center	San Joaquın Delta	Santa Rosa	
Licensure					Board of Licensed Vocational Nurse	and Psychiatric	Technician	ıners													
Occupation	Physical Therapy Asst. (Continued)				Psychiatric Technician	-:	12:	1-													

Educational Programs	Occupational Programs (Degree- Granting Authorized) Rancho Arroyo College	Occupational Programs	West Valley Occupational Center Hillcrest College Grossmont School District Health Careers Center California Pacific College Palo Vista College of Nursing and Allied Health Sciences Valley Vocational Center	University of California	Irvine San Francisco	California State Univ. and Coll.	Los Angeles Northridge San Diego	Independent Institutions
Certification				American Registry	or wantopsic Technologists			
Licensure				Department of	neattu Selvites			
Occupation	Psychiatric Technician (Continued)		-122	Radiologic Technolo-	Radiologic Technolo- gist, Therapeutic			

Loma Linda Southern California

Educational Programs
Certification
Licensure
Occupation

Radiologic Technologist, Therapeutic (Continued) Radiologic Technologıst, Diagnostic

Community Colleges

Antelope Valley Bakersfield

Cabrillo

Canada

Chabot

Chaffey City College of San Francisco

Compton

Cypress El Camino

Foothill

Fresno

Los Angeles City Long Beach Merced

Mt. San Antonio Merritt

Orange Coast

Pasadena

San Diego Evening San Diego Mesa Saddleback

San Joaquın Delta Santa Barbara

Santa Monica Santa Rosa

Education
Certification
Licensure
Occupation

Radiologic Technologist, Diagnostic Radiologic Technologist, Therapeutic (Continued)

onal Programs

Occupational Programs

West Valley Occupational Center St. Francis Hospital School of Radiologic Technology

St Johns Hospital School of Radio-logic Technology

St. Josephs Medical Center School of Radiologic Technology

San Bernardino County Hospital School of Radiologic Technology

Santa Monica Hospital School of X-Ray Technology

Sutter Community Hospital School of Radiologic Technology
Peninsula Hospital School of X-Ray

Technology O'Connor Hospital School of X-Ray Technology

Huntington Memorial Hospital School of X-Ray Technology

Daniel Freeman Memorial Hospital School of Radiologic Technology Californía Hospital Medical Center

School of Radiologic Technology City of Hope Medical Center School of Radiologic Technology

Associated Technical College Los Angeles County-USC Medical UCLA Center for the Health Sciences University Hospital of San Diego County

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Educational Programs	Occupational Programs (Cont.) Zellerbach Saron: Tumor Institute of Mt. Zion Hospital Cancer Foundation of Santa Barbara Stanford University Hospital LA County-Harbor General Hospital		Independent Institutions Loma Linda Mt. St. Marys Casa Loma Institute of Technology Community Colleges American River Butte Chabot Compton Crafton Hills Desert East Los Angeles El Camino Foothill Fresno Grossmont Los Angeles Valley Long Beach Mt. San Antonio
Certification			National Board for Respiratory Therapy
Licensure			
<u>Occupation</u>	Radiologic Technologist, Diagnostic Radiologic Technologist, Therapeutic (Continued)	Recreation Therapist	Respiratory Therapist -125-

Educational Programs
Certification
Licensure
<u>Occupation</u>

Respiratory Therapist (Continued)

Community Colleges (Cont.)

Victor Valley Santa Monica Orange Coast Saddleback Santa Rosa Rio Hondo Skyline Ventura Napa

Occupational Programs

Southland College of Medical-Dental-UCLA Center for the Health Sciences California College for Respiratory California Pacific College/Insti-Valley College of Medical/Dental California Paramedical and Tech-American College of Paramedical Legal Careers (3 locations) Eden Area Vocational Program Medical Training Institute tute of Medical Studies Arts and Sciences nıcal College Therapy Careers

North-West College of Medical and Dental Assistants

Educational Programs				Community Colleges Los Angeles Trade-Technical Long Beach Míssion
Certification				Association of Operating Room Technicians
Licensure	Department of Health Services	Board of Behav- loral Science Exam- iners (for Marriage Counselor)		
<u>Occupation</u>	Sanitarian	Sex Therapist	Sonographic Technician	Surgical Technician

San Joaquin Valley College
California Paramedical and Technical College
Simi Valley Adult School
American College of Paramedical
Arts and Sciences
Southland College of Medical-DentalLegal Careers
Maric College

Occupational Programs

EDUCATION AND TRAINING

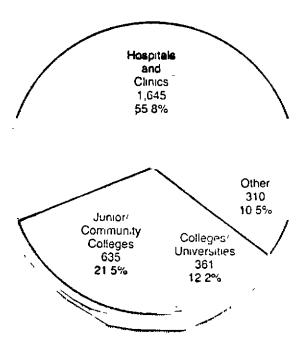
Historically, education for many allied health disciplines began either through coordinated efforts with existing programs in nursing or as on-the-job training in health care facilities. Individuals trained in this fashion then formed professional associations which in turn established standards for accrediting nonacademic clinical programs of study. The standards for medical technology, for example, which is among the oldest allied health fields, were developed in the early 1930s. As demand for allied health personnel and the cost of preparing them increased, however, on-the-job training became largely impractical, and training moved from clinical to academic settings. In 1950, the University of Pennsylvania established the School of Allied Health Professionals, the first allied health school in the country; in 1957-58, the University of Florida and Indiana University followed. At latest count, at least sixty-six colleges and universities have schools or divisions of allied health.

In 1966, the Allied Health Professions Personnel Training Act gave impetus to the creation of new programs and the strengthening of existing ones. Designed "to increase the opportunities for training of medical technologists and personnel in other allied health professions" and "to improve the educational quality of the schools training such allied health professions personnel," the Act provided grants-in-aid to public and private nonprofit training centers. As this federal funding became available for buildings, equipment, faculty salaries, and other operating costs, as well as for student stipends and tuition, local, state, and private funding sources also expanded. The proliferation of two-year community colleges and technical institutes with their certificate and associate degree programs, together with the ready availability of financing, fortuitously coincided with the burgeoning demand for allied health personnel, and postsecondary education became a partner of the health industry in producing allied health professionals.

The community colleges and technical institutes have not been totally responsible for the educational preparation of all allied health personnel, however Many health professionals require graduate or baccalaureate degrees. Indeed, there are pressures from our credentialed and credentialing society to develop baccalaureate programs to replace associate degree courses of study and postgraduate training to replace bachelor's level programs. Hospitals and clinics, too, maintain a significant number of allied health training programs (55.8% nationally), and other programs reside in medical schools (5%), U.S. government institutions (2 1%), special schools (2%), proprietary schools (.8%), and blood banks (.6%). The following graph developed by the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical

Association, although relying upon a different data base from this report, is helpful in showing the distribution of sponsorships of CAHEA-AMA accredited allied health programs in the U.S. 14/

FIGURE I
DISTRIBUTION OF SPONSORSHIP OF ACCREDITED ALLIED HEALTH
PROGRAMS NATIONALLY, 1978



The breakdown of allied health education programs is shown somewhat differently in the final report of a two-year study done by the National Commission on Allied Health Education (NCAHE): 52 to 54 percent are housed in collegiate settings, 33 to 35 percent in hospitals, 10 to 12 percent in postsecondary noncollegiate institutions like public vocational-technical institutes and private career schools, and I percent in the armed forces. 15/ Whatever the actual percentage differences may be, it is clear that colleges and universities sponsor a significant proportion of all allied health training programs in the country today. The NCAHE data (although skewed by a 20 percent nonresponse rate) indicates that in 1975 over half of the 3,000 institutions of higher education in the country sponsored at least one allied health program. Such programs were more likely to be offered by public collegiate institutions than by private institutions and by two-year institutions rather than fouryear institutions. 16/

The total number of allied health educational programs in operation today--academic and nonacademic, accredited and nonaccredited--is

not easily determined. From data available in 1979 from HEW's Division of Associated Health Professions, more than 11,000 programs could be identified nationally in 1975 with about 220,000 graduates. $\frac{17}{1975}$ Adding only a conservative percentage of increase for the period $\frac{1975-1980}{1975-1980}$, one can see that the education and training of allied health professionals is big business in itself.

In California, allied health training programs exist in all segments of postsecondary education. The University of California has only a few such degree-granting programs which can be readily identified from the regular data channels such as the Higher Education General Information Survey (HEGIS), but a recent inventory by a faculty committee reportedly has found a substantial number of professional certificate programs in allied health. 18/ The California State University and Colleges system has about eight major degree programs in allied health, plus a coordinating unit in the Chancellor's Office funded by a federal grant. The independent four-year institutions in California generally support only a limited number of allied health programs, the major exception being Loma Linda University, which has a number of programs within a School of Allied Health.

Large numbers of allied health programs of two years or shorter duration are located in the 106 public Community Colleges within the State. A somewhat smaller group of programs is available through secondary school districts—in high schools, regional occupational programs or centers, skills centers, or adult schools. Private vocational schools also play a significant role in a number of the allied health fields. A final group of programs is sponsored by hospitals, which are the primary employers in many allied health fields.

Data on enrollments and the number of graduates of these programs are not universally available or reliable. For degree programs in the University and the State University the data are generally quite good, subject to the problem of inconsistent labeling of programs from campus to campus, with enrollments and graduates identified by sex and ethnicity through the Commission's statewide information system. For independent institutions the HEGIS procedures are used, producing only the distribution by sex for graduates each year and data for enrollments by sex only in alternate years

Community College data have been difficult to collect. HEGIS has provided information on sex of graduates, but no data on enrollment. The Commission's first efforts to put Community College data into its information system have been disappointing. Sixty-three Community Colleges, including some of the largest in the State, reported no data on enrollment by major, and a number of other campuses had incomplete data on enrollment by major. However, data are available by sex for the graduates of the Community College allied health programs through HEGIS.

Information on enrollment and completions in allied health programs operated by secondary school districts is available through an annual reporting requirement imposed on vocational education programs by the State Department of Education, which is the agency with federally mandated information responsibilities in vocational education. Community Colleges also report data on vocational education programs, including those in allied health, through this mechanism.

Historically, it has been difficult to obtain data on enrollments and outputs from the private vocational schools. These schools have felt that such information was indeed private, in the same sense that their financial data were privileged, and that disclosures might put some schools at a competitive disadvantage within the industry. With increased participation in federal and programs requiring certain accountability, the private school industry has, in recent years, moved toward greater acceptance of a responsibility to report data to State and federal agencies. The Commission achieved a high degree of cooperation from the industry in carrying out the first "Career School Survey," using the federal survey instrument entitled, Survey of Programs and Enrollments, Postsecondary Schools. Data from that survey for 1978-79 are included in this report in several tables which list the schools by program but aggregate the data from all private schools operating each program.

The final group of allied health programs, those sponsored by hospitals, has also been difficult for educational agencies such as the Commission to monitor. Enrollment and output data for hospitalbased programs that are accredited by the Committee on Allied Health Education and Accredition/American Medical Association are generally reported in AMA publications, but it is virtually impossible to know the status of all non-accredited programs. At the State level, a different section of the Education Code covers hospital-based programs than that which deals with vocational schools. Apparently some hospital programs are reported through the "Career Schools Survey," some are identified through the annual reports made to the Health Facilities Commission, and some may not be reported at all. The Commission anticipates that through the attention devoted to allied health in this report it will be able to do a more comprehensive survey of hospital-based programs when it conducts the Survey of Programs and Enrollments, Postsecondary Schools in the future.

Data on enrollments in eight allied health programs in the University and the State University are shown in Table AH-3.

Several significant relationships are revealed by an examination of Table AH-3. First, and perhaps most surprising, in all of these fields there are more women than men enrolled. Counting all

TABLE AH-3 Enrollment, Public Institutions, Allied Health, Fall 1979

Program and Institution	Non Resident Allen	Non esident Alien		Black Mon- Hispanic M	And	American Indian Alaska Native	Astan Pacific Islander M F	e i i i i i i i i i i i i i i i i i i i	Hispanic M	일	₹ F		Eilipino M	Response M F	use H	Other M	<u> </u>	Iotal M	그는
Clinical Social Work																			
CSUC Undergraduate Los Angeles	0	0	6	21	-	-	1	7	5 18		7 3	30	0 0	4 13	æ	0	0	27 8	85
Graduate Fresno San Diego San Francisco	000	000	1 0	9	0	000	000	- 0 0	3 3 0 1 1		16 1 7 3 5 2	13 32 25	0 0	10 7 7 11 11 11 11 11 11 11 11 11 11 11 11	2 6 15	000	0 - 1	33 2 14 4 12 4	21 41 49
Dental Hyglene																			
UC Undergraduate San Francisco	0	0	0	-	0	0	0	71	1 3		0 2	28	0 2	0	o	0	1	1 4	7.7
Medical Laboratory Technology																			
CSUC Undergraduate Bakersfield Chico Dominguez Hills Los Angeles Sacramento San Francisco	1 4 4 1 1 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5	381143	0-164266	0 0 10 8 8 12 3	000007	00-00	22 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	0 0 14 27 6 6 6 16	0 1 3 3 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1		2 113 2 110 2 120 3 17 4	4 21 21 16 37 36	1 0 0 0 8 18 3 17 1 1 16 26 2 4	0 1 1 2 1 1 1 2 1 2 1 2 2 3 3 4 3 4 3 4 3 4 3 4 3 4 3 4 3 4 3	0 8 8 117 117 331	177000	0000145	4 117 3 37 7 57 10 55 10 881 18	5 32 72 103 81 88 95
Graduate San Francisco	7	7	0	7	c	en	m	15	-	7	18 4	07	1	9 1	18	0	_	34 8	98
Occupational Therapy																			
CSUC Undergraduate San Jose	0	-	0	'n	9	6	0	20	0	'n	ъ Б	66	1 1	5 5	56	0	∞	6 16	198
Graduate San Jose	0	0	0	1	0	0	0	2		-	0	12	0 0	0 1	13	0	0	0	53

TABLE AH-3 (Continued)

Program and Institution	Mon Resident Alien		Black Non- Hispanic		American Indian Alaska Native	can ska ve	Asian Pacific Islande	Asian Pacıfic İslander M	H1st	Hispanic M F	₹E	Mh1te M F	E	Eflipino M F	Res	No Response M	3 S €	Other F	Total	평
Physical Therapy UC Undergraduate San Francisco	0		0	_	0	1		2	Ф	¢	Q	27	٥	2	0	0	0	0	7	33
CSUC Undergraduate Fresno Long Beach Northridge	000	• *	0 11 37 7 6		2 1 0	നനമ	6 9 5	8 30 15	7 15 5	10 19 8	40 41 29	160 205 86	0 1 2	3 6 0	15	16 155 26	2 5 0	12 3	67 2 120 4 59 1	204 467 147
Public Health UC Udergraduate Los Angeles	0		1 3	-	0	0	0	4	0	en	9	18	-	-		0	0		•	31
Graduate Berkeley Los Angeles	16 13 2 5		4 10 0 4		12 1	12 0	8 4	12 5	5	10	63 39	118 48	0	7 0	5	8 12	0	12	114 1	1 8 6 76
Professional Los Angeles	12 19		6 9		0	4	7	14	6	14	56	131	0	2	13	26	0	0	98 2	219
Nationalist recinionsky UC Graduate Tryine	0		0		c	٥	0	o	0	0	en	0	0	0	0	0	0	0	e	0
CSUC <u>Undergraduate</u> Northridge	0		0		0	0	0	Φ	0	0	3	11	1	0	**	1	C	-	6	14
Graduate San Diego	0		0 0	_	0	0	0	6	0	0	2	2	0	0	7	0	-	-	4	9

	:		American	***							
Program and Institution	Resident Allen	Black Non- Hispanic M F	Alaska Alaska Native	Astan Pacific Islander M F	Hispanic M F	White	Eilipino M F	No Response	Other M	Iotal M	ভ
Speech Pathology/Audiology											
csuc											
Undergraduate	•		,								67
Chico	o -	0 -	 	n	O 7	5 104 16 128	90	2 24 2 14	1 4	22 1	991
Fullerton	. 0										34
Havvard	0										89
Humboldt	0 0										72
Long Beach											.15
Los Angeles	0		0 1								60
Northridge											2
Sacramento											52
San Diego											25
San Francisco											79
San Jose											36
Stanielaus	0 0			0 0							31
Graduate											
Chico	0 0			0 0		1 11	0 0	3 2	0	7	14
Fresno	0 0					1 21				7	47
Fullerton	0 0	0	0	0 2	0		0	7 0	0	0	56
Humboldt											Ξ;
Long Beach										vo .	56
Los Angeles										.	77
Northridge										7	19
Sacramento										m (32
San Diego										η.	9
San Francisco	0									4	19
San Jose	1 1					•				⊶ .	4
Stanislaus	1 0									-	7.7

undergraduate and graduate enrollment, including some miscellaneous enrollment not shown in the table, it is evident that the percentage of women is greatest in dental hygiene (97.9%), followed in descending order by occupational therapy (96.5%), speech pathology/audiology (91.0%), physical therapy (76.7%), clinical social work (69.4%), medical laboratory technology (67.0%), public health (57.6%), and radiologic technology (52.9%).

Ethnic minorities are represented unevenly. Blacks make up 18.1 percent of the enrollment in clinical social work, 8.4 percent in physical therapy, and 8.2 percent in medical laboratory technology; their lowest rate of participation is 4.0 percent in public health and 3.8 percent in radiologic technology.

For Chicanos, the highest participation is also in clinical social work with 14.7 percent of the enrollment, followed by public health (9.4%) and physical therapy (8.1%). The lowest percentage of enrollment for Chicanos is in occupational therapy (3.6%) and radiologic technology (3.8%).

Contrasted with Black and Chicano enrollment is that of Asians, a smaller group generally well represented in the health professions. In medical laboratory technology 23.1 percent of the total enrollment is Asian; in occupational therapy 13.9 percent is Asian, and in public health, 10.2 percent. The lowest percentage of enrollment of Asians occurs in clinical social work, 3 4, with speech pathology/audiology showing 4.3

Information is also available by sex and ethnicity for the graduates in these same eight programs in the public four-year institutions. Table AH-4 displays these data.

The only apparent anomaly between the relationships shown for enrollment in Table AH-3 and those for graduates in Table AH-4 above is in radiologic technology, where the enrollment was shown to be more than half female, and yet no female graduates are shown. At Northridge, the designation of an undergraduate program as radiologic technology for purposes of enrollment but not for graduates explains this anomaly.

Data on graduates of six allied health programs in independent institutions are shown in Table AH-5, by degree level and sex, as reported through HEGIS.

The largest single source of trained allied health personnel is California's Community Colleges. Data on completions—degrees or certificates—in a number of allied health programs are displayed in Table AH-6.

TABLE AH-4

Degrees Conferred, Public Institutions, Allied Health, 1978-79

Program and Institution	Mon Resident Alfen M F	ent F	#15p	Black Mon- Hispanic M F	American Indian Alaska Mative	Tean Tan Tee	Asian Pacific Islande M	Asian Pacific Islander M	Hispanic M	an ic	¥ ¥		E1 Jipino M	7. 100	S S	No Besponse	Other W	5 世	Iotal M F	e +
Clinical Social Work																				
CSUC B S Degree Los Angeles	0	0	7	9	٦	e e	0	0	0	ī	0	13	0	0	0	7	0	0	2	5 6
M S W Degree Fresno San Diego San Francisco	000	000	0 0	0 1 1	000	000	600	0 66 6	0 - 0	000	10 15	20 8	000	000	0 1 5	5 1 3	000	000	13 17 8	8 25 14
Deutal Hygrene																				
UC B S Degree San Francisco	0	0	0	0	0	0	0	S.	•	0	0	<u>se</u>	-	•	Φ	0	0	0	7	23
Medical Laboratory Technology																				
CSUC B S Degree Dominguez Hills Los Angeles San Francisco	0	0 0 m	1000	100	000	000	0 5 10	$\frac{2}{17}$	0 7 0	330	0 7 0 10	1 14 19	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2.23	1 1 1	730	7 0 7	0 0 1	4 30	7 32 49
M S Degree																				
Dominguez Hills San Francisco Sonoma	000	000	000	000	000	000	000	0	000	000	0 - 0	0 3 0	000	000	48 0 5	64 1 8	000	000	4.8 4.2 5.4	3 9 80
Occupational Therapy																				
CSUC B S Degree San Jose	-	0	0	-	0	0	0	'n	0	2	т г	04	_	0	1	19	0	4	9	7.1
M S Degree San Jose	0	_	0	0	0	0	0	0	0	0	0	0	•	0	0	0	0	0	0	,i

TABLE AH-4 (Continued)

Program and Institution	Non Resident Alien	ent -	Black Non- Hispani	Black Non- Hispanic	American Indian Alaska Native	eka Ye	Asian Pacific Isl and e	Asian Pacıfic Isl ander	H1spenic	B Ĉ	M ite	2	Eflipino	01.10	Res	*o Ponse	oth th	ن	Iot	Ę
Physical Therapy	E	<u> </u>	Σ	L	Σ	<u> </u>	3 .	<u> </u>	<u>=</u>	<u>.</u>	Σ	 	=	ļ ļĿ	 ==	<u></u>	L 2E	۳	<u>*</u>	
UC B S Degree San Francisco	0	0	0	0	0	0	-	2	0	o	4	23	c	0	0	0	0	7	'n	26
CSUC B S Degree Fresto Long Beach	00	00	00	00	00	00	0 1	3 0	00	0 4	13	93	00	00	9	13 7	0 4	0	10 16	13
Public Health																				
UC B S Degree Berkeley Los Angeles	0 0	0 0	00	10	00	00	00	0 1	00	00	0 €	1 16	00	0 0	00	00	1 0	0	0 4	1 9
M P H Degree Berkeley Los Angeles	18	4 2	4 4	80 7	7	7 2	5 4	√ 7 ∞	2 0 60	3	53	96 96	00	3.1	4 4	e 2	60	2 5	92 71 1	97 126
CSUC B S Degree Los Angeles San Diego	1 0	1 0	1 0	~ 0	00		1 0	0	40	00	ınα		00	00	00	00	0 0	90	12	4 -
HPH Degree Long Beach Northradge San Jose	0 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	100	000	000	000	200	000	0 0 7	0 0 1	000	-0-	0 7 12	000	200	000	0 7 6	000	0	3 - 0	2 10 27
Radiologic Technology																				
UC M S Degree Irvine	0	0	٠	0	0	•	0	0	•	•	2	0	0	•	-	0	0	0	e	0
CSUC H S Degree San Diego	0	0	0	0	0	0	•	0	0	0	5	_	-	0	-	•	0	0	7	-

TABLE AH-4 (Continued)

Program and	Non Resident	Black Non-	American Indian Alaska	Astan Pecific				<u>.</u>		
Institution	A) ien	Hispanic M	Mative M F	Is Jeruder M F	Hispanic M	White M	Eilipino M F	Response M	Other M	Total M F
Speech Pathology/Audiology										
CSUC										
B S Degree	,									
Chico	0	0				0 15				
Fresno	0					05 5				
Hayward	0									
- Humboldt	0 2									
Long Beach	0 0									
Los Angeles	0									
Northridge	0 0	0 0								
Sacramento	0 0									
San Diego	0									
San Francisco	0									
San Jose	0 0	0 1	0 0	0	0 1	0 15	0 1	0 0	0 0	31
M S Degree										
Chico	0 0				0 0	1 0				
Fresno	0 0									
Humboldt	1 6									
Long Beach	0									
Los Angeles	0									
Northridge	0 0	0	0 2	0 1	0	2 26	1 0	$\frac{1}{0}$	0	2 44
Sacradento	0									
San Diego	0									
San Francisco	0				0					
Stanıslaus	0			0 0	0			7 0		1 19

TABLE AH-5

Degrees Conferred in Allied Health, By Sex, California Independent Institutions
1978 - 1979

Program and Institution		relor's rees F		ster's Jrees F	Doctor' Degrees M F	
Dental Hygiene						
Loma Linda	0	35				
Medical Laboratory Technology						
California Lutheran	0	2				
Holy Names	0	3				
Loma Linda	12	11				
Pacific Union	6	7				
Occupational Therapy						
Loma Linda	1	19				
Univ. of Southern California	1	23	0	12		
Physical Therapy						
Loma Linda	19	35				
Stanford	_		7	22		
Univ. of Southern California	0	4	12	26		
Public Health						
Loma Linda	2	5	31	28	10 2	
Speech Pathology/Audiology						
Chapman	0	8	0	7		
Loma Linda	0	6	Ö	7		
Pacific Union	Ō	8	•	•		
Univ of LaVerne	0	4	0	3		
Univ of Pacific	2	4	1	17		

TABLE AH-6

Completions in Allied Health Programs Within California Community Colleges
1979

Program and Institution		rogram Comp e Degrees	letions Certif	icatos
2110 01 04 01011	M	F	M	F
5201 Health Services Assistant Technologies, General				
American River	0	2	0	0
Antelope Valley	0	1	0	0
Bakersfield	3	10	0	0
Butte	1	1	0	0
Compton	2	1	0	0
Crafton Hills	1	14	0	0
East Los Angeles	0	1	69	17
Gavilan	0	0	7	0
Los Angeles City	39	121	0	0
Los Angeles Pierce	3	8	0	0
Los Angeles Southwest	12	7	0	0
Los Angeles Valley	30	170	0	0
Mendocino	0	1	0	0
Monterey Peninsula	2	0	0	0
Orange Coast	2	3	0	0
Pasadena	6	16	16	6
Sacramento City	0	1	0	0
San Bernardino Valley	0	1	0	0
Santa Rosa	0	1	0	0
Shasta	0	0	0	8
	$\overline{101}$	359	92	31
5202 Dental Assistant Technologies				
Alameda	0	2	0	8
Allan Hancock	0	11	0	0
Bakersfield	0	4	0	16
Cabrillo	0	2	0	9
Cerritos	0	11	0	13
Chabot	0	15	0	0
Chaffey	0	26	0	0
Citrus	0	24	0	0
Contra Costa	0	2	0	11
Cypress	0	11	0	0
Diablo Valley	0	14	0	2
East Los Angeles	0	1	0	0
El Camino	0	1	0	0

Program and	Р	rogram Com	pletions	
<u>Institution</u>	Associat	e Degrees	Certi	ficates
	М	F	M	F
Foothill				
Grossmont	0	5	0	18
	1	8	0	0
Long Beach City Marin	0	5	0	0
Merced	0	11	0	0
Modesto	0	3	0	15
Monterey Peninsula	0	11	0	0
	0	7	0	0
Orange Coast Palomar	0	4	0	13
Pasadena	0	0	0	13
Redwoods	0	6	0	0
	0	. 8	0	0
Reedley Rio Hondo	0	18	0	0
	0	22	0	0
Sacramento City	0	21	0	0
San Diego Mesa	0	7	0	12
City College of San Francisco	1	17	0	0
San Jose City	0	7	0	1
San Mateo	0	6	0	0
Santa Barbara	0	1	O	0
Santa Rosa	0	13	0	0
Yuba	<u>0</u>	4	0	0
	2	308	ō	$\overline{131}$
5203 Dental Hygiene Technologies				
Bakersfield	_	_		
Cabrillo	0	1	0	0
Cerritos	0	13	0	19
Chabot	0	18	0	0
	0	17	0	0
Cypress Diablo Valley	0	3	0	0
East Los Angeles	0	4	0	15
Foothill	0	1	0	0
·	2	19	0	0
Fresno City Long Beach City	0	20	0	0
Orange Coast	0	1	0	0
Pasadena	0	1	0	0
Sacramento City	Ó	19	0	0
	1	14	0	0
West Los Angeles	$\frac{0}{3}$	14	<u>0</u>	_0
	3	145	0	34
5204 Dental Laboratory Technologies				
Diablo Valley		1	^	•
Monterey Peninsula	6 3	1	3	1
Orange Coast	3	0 4	0	0
	J	4	10	3

Program and Institution		rogram Com e Degrees F		i cate s F
Pasadena	1	6	0	0
Riverside	0	0	5	3
City College of San Francisco	6	5	0	0
Santa Ana	_0	$\frac{2}{18}$	_0	<u>0</u> 7
	<u>19</u>	18	18	7
5205 Medical or Biological Laboratory				
Assistant Technologies				
Bakersfield	0	2	0	0
Cabrillo	0	1	0	Ō
Cypress	2	0	0	0
Desert	0	0	0	17
De Anza	0	6	0	0
East Los Angeles	0	2	0	0
El Camino	9	16	0	0
Fullerton	0	2	0	0
Los Angeles Pierce	4	0	0	0
Orange Coast San Diego Mesa	1	3	0	0
Santa Ana	0 0	4 2	0	7
Siskiyous	0	0	2 1	10 0
Yuba		1		0
	$\frac{5}{21}$	<u> 39</u>	<u>0</u> 3	34
5207 Radiologic Technologies (X-Ray)				_
Antelope Valley	1	3	0	0
Canada	5	7	ŏ	ŏ
Chaffey	10	6	ō	Ö
Compton	0	1	0	Ó
Cypress	6	18	0	0
El Camino	8	12	0	0
Foothill	5	25	0	0
Fresno Long Beach City	7	7	0	0
Merced	9	18	0	0
Merritt	4 12	10 19	3	11
Mt. San Antonio	8	12	0 3	0 0
Orange Coast	6	19	4	5
Pasadena	4	10	0	0
Riverside	0	1	ŏ	0
San Diego Mesa	8	13	ŏ	ŏ
City College of San Francisco	10	10	Ö	ŏ
San Joaquin Delta	1	6	0	0
Santa Barbara	3	14	0	0
Yuba	12	6	_0	_0
	119	217	10	16

Program and Institution		ogram Comp Degrees F		icates F
5210 Occupational Therapy Technologies				
Cerritos Crafton Hills Long Beach City Pasadena	11 2 0 0 13	0 2 1 3 6	0 0 0 0	0 0 0 0
5211 Surgical Technologies				
Cerritos Golden West Los Angeles Trade-Tech	6 1 0 7	5 3 0 8	0 1 6 7	0 3 0 3
5212 Optical Technologies (including ocular care, ophthalmic, optometric technologies)				
Canada Citrus Crafton Hills Pasadena San Diego City	5 3 3 1 15	6 1 1 1 6 15	0 3 0 0 1 4	0 1 0 0 14 15
5213 Medical Record Technologies				
Chabot Cypress East Los Angeles San Diego Mesa City College of San Francisco West Valley	0 1 0 0 1 0 2	19 6 17 13 17 15 87	0 0 0 0 0 0	0 0 21 0 0 0 0 21
5214 Medical Assistant and Medical Office Assistant Technologies				
Alameda Allan Hancock Bakersfield Butte Cerritos Chabot Citrus	0 0 0 0 0 0	7 19 11 0 10 13 6	0 0 0 0 0	15 0 22 5 7 0 8

Program and	Pr	ogram Comp	letions	
Institution	Associate		Certii	icates
	М	F	М	F
Contra Costa	2	10	7	10
Cosumnes River	2	13	1	13
Cypress	1	5	0	0
Desert	0	6	0	0
De Anza	1	0	0	0
East Los Angeles	0	0	0	5
El Camino	0	1	0	1
Fresno City	0	5	0	5
Imperial Valley	0	5	0	1
Indian Valley	0	0	0	2
Long Beach City	0	9	0	5
Los Angeles Harbor	0	2	0	0
Los Angeles Valley	3	9	0	2
Modesto	0	8	0	0
	0	9	0	0
Monterey Peninsula Ohlone	1	10	0	0
	0	7	0	8
Orange Coast Palomar	0	7	0	14
Pasadena	0	4	0	8
Redwoods	0	7	0	0
Rio Hondo	0	3	0	0
	1	4	0	0
Riverside	0	5	0	4
Saddleback	0	6	0	3
San Bernardino Valley	0	1	0	0
San Diego Mesa	0	10	1	14
City College of San Francisco	0	16	0	0
San Mateo	0	12	0	0
Santa Ana	0	2	0	1
Santa Barbara	0	0	0	13
Santa Rosa	0	5	0	0
Ventura	0	4	0	3
West Hills	0	1	0	0
West Valley	<u>0</u>	16	<u>o</u>	0
	9	258	$\overline{2}$	154
5215 Inhalation Therapy Technologies				
American River	3	10	۸	٥
Butte	14	18	0 0	0 0
Compton	0	4	0	0
East Los Angeles	9	8	3	1
Foothill	4	9	3 0	0
Fresno City	7	11	0	0
Grossmont	10	6	0	Ö
Long Beach City	6	13	0	0
Los Angeles Valley	2	24	13	10
	4	44	13	10

TABLE AH-6 (Continued)

Program and <u>Institution</u>	Pr Associate M	ogram Comp Degrees F		icates F
Mt. San Antonio	14	9	6	6
Napa	6	8	0	0
Orange Coast	10	3	2	2
Rio Hondo	5	6	0	0
San Bernardino Valley	2 3	3	0	0
Santa Monica	3	9	6	12
Santa Rosa	5	3	1	0
Skyline	7	11	11	14
Ventura	0	1	2	2
Victor Valley	6	$\frac{2}{158}$	0	2 49
5016 Devokesture Taskurlanın ()	$\overline{113}$	158	44	49
5216 Psychiatric Technologies (including mental health aide)	ng			
Bakersfield	6	12	0	0
Cerritos	0	0	7	5
Crafton Hills	2	2	Ó	Ō
Cuesta	0	2	0	0
Cypress	3	6	0	0
East Los Angeles	1	0	1	
Golden West	6	33	2	2 3 8
Los Angeles Trade-Tech	1	0	5	8
Los Angeles Valley	0	0	5	6
Mission	7	9	1	2
Mt. San Antonio	1	11	0	0
Napa	5	5	0	0
Orange Coast	1	0	0	0
Porterville	4	0	28	37
Rio Hondo	2	2	0	0
Sacramento City	1	5	0	0
San Joaquin Delta	6	27	0	0
Santa Rosa	1	5	15	37
Ventura	0	2	0	0
	47	121	64	100
5217 Electro Diagnostic Technologies (including EKG, EEG, etc.)				
Orange Coast	4	4	2	8
5218 Institutional Management Technolog	gies			
Bakersfield	1	0	0	0
Cerritos	2	1	0	1
Foothill	0	0	ì	0

TABLE AH-6 (Continued)

Program and Institution	Pr Associate M	ogram Comp Degrees F		ficates F
Fresno City	0	1	0	0
Los Angeles Valley	0	0	0	2
Mission	0	0	2	
Orange Coast	2	2	1	8 3 0
Pasadena	0	1	0	
San Bernardino Valley	2	0	0	0
San Diego City	0	1	0	0
San Diego Evening	$\frac{4}{11}$	1/8	$\frac{1}{5}$	$\frac{0}{14}$
5219 Physical Therapy Technologies				
Cerritos	1	12	0	1
Compton	1	0	ŏ	ō
Cypress	0	2	Ö	ŏ
De Anza	11	30	Ō	Ŏ
Imperial Valley	1	3	0	0
Long Beach City	0	2	0	0
Los Angeles Pierce	4	0	0	0
Los Angeles Southwest	1	0	0	0
Modesto	0	1	0	0
Monterey Peninsula	0	1	0	0
Orange Coast Pasadena	1	2	0	0
San Bernardino Valley	5 1	6	0	0
San Diego City	0	6 1	0	0
San Diego Mesa			0	0
241 21C20 11C30	$\frac{1}{27}$	<u>9</u> 75	<u> </u>	$\frac{0}{1}$
W000 011 -	21	13	U	1
5299 Other, Emergency Medical Care				
Butte	0	1	10	2
Canyons	0	0	36	42
Crafton Hills	5	1	0	0
Imperial Valley	0	0	11	4
Lassen	0	0	26	27
Santa Ana	11	0	1	0
Skyline Southwestern	0	0	103	25
Southwestern	$\frac{0}{16}$	$\frac{1}{3}$	100	0
	10	3	188	100
5299 Other, Mortuary Science				
Cypress	0	0	3	17

TABLE AH-6 (Continued)

Program and	Pro	gram Comp	letions	
<u>Institution</u>		Degrees	Certif	icates
	M	F	M	F
5299 Other, Nurses Aide				
Southwestern	0	0	3	17
5299 Other, Nutrition/Dietetic Asst.				
Bakersfield	0	6	0	10
Orange Coast	$\frac{1}{1}$	$\frac{12}{18}$	$\frac{0}{0}$	<u>9</u> 19

Table AH-6 illustrates several points. The mismatch between programs and jobs can be inferred from the 5201 category: Health Services Assistant Technologies, General. What is a graduate of such a program prepared to do? Considering the size of this program, a more specific job-related orientation seems necessary.

Large Community College programs exist in fields in which other sectors—especially public schools and private vocational schools—also have large programs. This is particularly true of dental assisting and medical assisting.

Men are not outnumbered by women in all programs. The output of men is greater than that of women in emergency medical care, dental technology, and institutional-management technology. But there are no male-dominated fields as there are fields dominated by females.

A number of allied health fields produce only a handful of graduates annually. (There are at least seventy-five institutional programs with five or fewer graduates.) If this situation characterizes these programs every year, questions may be raised concerning whether these programs have adequate resources to insure quality.

In general, there seems to be adequate geographical distribution of allied health programs, but some Community Colleges seem to offer none of the programs listed in Table AH-6.

Nursing has been discussed elsewhere in this report, and is not included in this allied health section. However, because data on licensed vocational nurses (LVNs) were not available for the Commission's 1978 Plan, and because the HEGIS reports do include data on graduates in this field, an additional table is being provided to establish a basis for future review of output of LVN programs. Table AH-7 contains information on 1978-79 completions in these programs.

With both associate degree and certificate programs leading to LVN licensure, the confusion generated by multiple educational levels for nursing licensure, as discussed in the 1978 Plan, is compounded.

Data on completions in the allied health programs sponsored by public secondary schools are reported through the vocational education reporting system. Table AH-8, which is modified from material in the California Vocational Education Accountability Report, 1977-78, displays program completions in such programs, along with completions in Community Colleges. An additional column has been added showing occupational programs as reported in the "Career Schools Survey" instrument, although the data in this column are for 1978-79 rather than for 1977-78. The first two columns in the table

TABLE AH-7
Completions In Community College Licensed Vocational Nursing Programs

Program and	Pr	ogram Comple	tions	
Institution	Associate			ficates
	M	F	M	F
5209 Nursing, Licensed Vocational Nurs	e			
Allan Hancock	0	16	0	0
American River	0	4	0	0
Antelope Valley	0	3	0	0
Bakersfield	0	11	6	40
Barstow	0	0	0	17
Butte	0	10	0	22
Cabrillo	3	1	4	28
Canada	0	2	0	0
Cerritos	1	17	0	29
Canyons	0	7	0	0
Cerro Coso	0	13	Ō	Ö
Chaffey	0	0	Ō	6
Citrus	0	6	1	44
Columbia	1	0	0	0
Compton	0	2	Ö	Õ
Contra Costa	0	6	Ō	9
Cypress	0	3	0	0
Desert	1	Ō	3	27
De Anza	Ō	0	ĺ	10
El Camino	0	17	ō	0
Fresno City	1	12	Ö	13
Gavilan	0	0	Ö	16
Glendale	0	5	4	49
Golden West	Õ	6	Ö	ó
Imperial Valley	1	6	Ö	9
Laney	1	5	i	28
Lassen	0	0	2	14
Long Beach City	2	40	ō	0
Los Angeles Harbor	0	28	ō	0
Los Angeles Mission	0	1	Õ	0
Los Angeles Trade-Tech	2	12	4	62
Los Angeles Valley	2	26	ò	0
Los Medanos	0	0	1	32
Marin	i	7	0	0
Merced	Ō	7	1	23

TABLE AH-7 (Continued)

Program and	F	orogram Cor	mpletions	
Institution		te Degrees		
· · · · · · · · · · · · · · · · · · ·	M	F	M F	
Mira Costa		_		
Mission	0	0	1 19	
Modesto	0	7	1 40	
	0	9	1 27	
Mt. San Antonio	0	32	0 0	
Mt. San Jacinto	0	0	1 30	
Napa	1	5	0 0	
Pasadena	0	11	3 41	
Redwoods	0	2	0 0	
R10 Hondo	1	2	0 0	
Riverside	0	2	3 25	
Sacramento City	0	19	5 53	
Saddleback	0	2	0 0	
San Bernardino Valley	0	1	0 0	
San Diego City	4	19	3 38	
San Diego Mesa	2	14	2 28	
San Joaquın Delta	0	40	0 0	
San Mateo	0	4	0 0	
Santa Ana	2	10	8 46	
Santa Barbara	0	4	0 0	
Santa Monica	1	5	1 24	
Santa Rosa	0	Ō	2 26	
Sequoias	0	ì	3 20	
Shasta	ō	2	0 9	
Sierra	i	17	1 15	
Siskiyous	ō	0	1 10	
Solano	ő	2	0 0	
Southwestern	1	3	4 29	
Ventura	0	1	0 16	
West Valley	0	9	0 0	
Yuba	0	5	0 0	
	29	5 02	$\frac{6}{68}$ $\frac{6}{974}$	

TABLE AH-8

Completions in Allied Health Programs in Vocational Education

		Cirront	Annual 10th		Сощ	Completions	100000
OF Code	Instructional Program	Employment	Openings	Total	Secondary	College	Programs
0000 20	Health Occupations Education	0	0	23	23	c	c
001 0100		0	0	114	114	0	- -
07 0101	Dental Assisting	22,911	2.432	2.919	18	1.075	1.826
07 0102	Dental Hygiene	4,061	400	382	0	382	0
	Dental Laboratory Fechnology	3,547	184	580	5	266	314
6610 /0	Other Dental	0	0	128	29	0	06
07 0200	Medical Laboratory Technology	0	0	0	ì	0	0
07 0201	Cytology	1,044	79	•			ve
	Histology	1,021	7.7	0			· c
07 0203	aboratory A	18,446	1,383	108	0	20	82
	dıcal Laborat	0	0	10	0	10	30
		0	0	336	336	0	0
	Nursing	89,063	6,684	3,932	0	3,862	70
	Practical Nursing	31,800	2,725	3,739	502	2,940	297
	Nursing Assistance	69,267	5,196	4,508	2,970	1,158	380
	Psychiatric Aide	5,650	427	684	91	587	81
	Surgical Technician	2,127	162	20	0	31	19
	Home Health Aide	355	56	259	52	207	0
	Other Nursing	0	0	651	4	592	55
	Occupational Therapy	66	6	26	0	26	0
	Physical Therapy	3,489	329	165	0	81	84
	Prosthetics	004	28	38	0	38	0
	Orthotics	1,661	1.23	0	0	0	0
	Other Rehabilitation	0	0	13	0	13	0
	Radiologic	0	0	75	0	75	0
	Radiologic Technology	7,811	589	829	0	571	258
	Radiation Therapy	NA	NA	NA	Ν	NA	2
	=	109	4.5	ហ	0	0	ī
	Radiologic Occupations, Misc	NA	NA	ΑN	NA	NA	7
	Ophthalmic	0	0	175	0	61	114
	Ophthalmic Dispensing	2,283	125	40	0	70	0
	Orthoptics	667	38	0	0	0	0
	Optometric Assistant	0	c	24	0	24	0
	Environmental Health	0	0	42	0	42	0
	Radiological Health Technician	375	28	0	0	0	0
	Santarian Assistant	224	10	0	0	0	0
	Other Environmental Health	0	0	33	0	33	0
	Mental Health Technology	0	0	208	0	200	6 0
		0	0	211	16	195	0
	Other Mental Health Technology	0	0	0	0	0	0
	С	0	0	145	88	57	0
07 0901	Electroencephalograph Technician	1,136	87	77	0	0	77

TABLE AH-8 (Continued)

					Coult	Completions	
		Current	Annual Job			Community	Occupational
OE Code	Instructional Program	Emp loyment	Openings	Total	Secondary	College	Programs
07 0902	Electrocardiograph Technician	2,489	190	113	0	7.8	35
07 0903	Inhalation Theiapy	3,187	240	853	48	598	207
07 0904	Medical Assistant	2,285	195	4,008	303	1,389	2,316
07 0905	Central Supply Technician	5,757	392	0	0		
9060 20	Community Health Aide	0	0	50	0	20	0
07 0907	Medical Fmergency Technician	6,754	540	3,591	112	2,959	520
07 0908	Food Service Supervisor	0	0	134	0	134	0
07 0909	Mortuary Science	861	20	19	0	62	2
07 0910	Orthopedic Assisting	0	0	11	0	11	0
07 0915	Medical Record Technologies	NA	NA	NA	NA	NA	31
07 0920	Physiciana Assistant	NA	NA	NA	NA	NA	81
00 600	Other Health Occupations Education	0	0	2,115	579	1,037	539
	Total, All Programs	289,223	22,763	31,632	5,210	18,964	7,458

California Vocational Education Accountability Report, 1977-78 (all data are for 1977-78 except those for Occupational Programs), supplemented by 1978-79 data on Occupational Programs from Private Career School Survey conducted by CPEC Source

display data on the current employment and the anticipated annual job opportunities in each field, both of which have been determined by the Department of Employment Development.

It is necessary to exercise caution in drawing conclusions from this table, since the data have been compiled from separate sources. Further, it is impossible to validate the data--by comparing Community College completions as reported in the California Vocational Education Accountability Report and through HEGIS--because the numbers are for different years. Finally, assuming for purposes of comparison that the years were the same, Table AH-8, based on data from the Accountability Report reports substantially more output than does HEGIS in LVN, nursing aide, dental assisting, medical assisting, emergency medicine, and a number of other programs. For 1977-78, the Accountability Report indicates a total of 18,964 completions in Community College allied health programs. By contrast, HEGIS reports only 8,807 total completions for 1978-79 in Community College allied health programs.

Thus, inadequacy and noncomparability of information must be identified as the first problem in dealing with the allied health fields. While the Commission feels that the initial attempt in this report to define, identify, and count the programs and participants in allied health education has been worthwhile, it is equally certain that an enormous task lies ahead in developing a system that can monitor these fields.

The lack of identity and unity within the allied health fields is a second problem, and one which contributes to the fragmentation of information. If "allied" means joined together in a common purpose, then these health-related fields do not deserve that appelation. The absence of any commonality of interest among allied health fields, means that no one speaks authoritatively for the entire field in legislative or professional matters. At the same time, most individual fields are not large enough to achieve strong professional standing on their own, and to develop associations with effective information and legislative staffs. Also, being largely female fields, a number of allied health occupations may encounter the same problem that confronts nursing, that of achieving professional recognition from the dominantly male fields of medicine and hospital administration. As a result of all these circumstances, the impact of the allied health fields upon health planning or in shaping the health industry is relatively limited, even in supplying basic information on its own practitioners and trainees.

A third, interrelated problem is the lack of career mobility within the broad area of allied health. Because occupations are so narrowly defined and have so little vertical distance between entry-level and senior positions, it is possible for a person soon to reach a professional dead end from which he or she cannot escape without retraining. Changes in technology or philosophy can accelerate this process; consider what would happen to radiology technicians if, for reasons of radiation safety, sonography were to replace radiology as a diagnostic procedure. Excessive specialization can result in a number of people being locked into technician-level jobs with limited salary potential and no means of redirecting their careers without additional training.

There have been efforts to develop "core" curricula, common to a number of fields, in the health sciences to increase the possibility that a person could shift from one field to another in pursuit of career opportunities, but these efforts have not significantly enhanced career mobility in allied health. Other efforts at academic articulation between segments of allied health education have failed to make the pathways for entry into allied health any easier to travel than the career paths between fields.

A fourth problem resides in various conflicting pressures for change in health care delivery. These pressures make it difficult to predict the future for allied health. On the one hand, societal and governmental pressures for more cost-effectiveness in health care might result in a larger role for those relatively low-cost allied health practitioners who could be used in lieu of higher-level professionals. Denturism is perhaps the best-known example of this possibility, but there are a number of other fields in which senior professionals could also be bypassed.

On the other hand, it is conceivable that economic circumstances could force senior professionals to reclaim some of the functions previously delegated to allied health personnel. Dentistry again provides an example; in the event of a surplus of dentists it is quite possible that a dentist might return to performing tasks which would displace the dental assistant and dental hygienist. In nursing, the move toward "basic" nursing has a philosophic, rather than an economic, orientation, but the effect is the same. the displacement of nursing aides and orderlies as RNs reclaim functions they once held.

Other factors that could affect the future role of allied health within the total health care profession include the reluctance of the Legislature to establish new categories of licensed health personnel along with the State's cautious exploration of possible de-licensure of one or two fields, and shifting viewpoints regarding the educational levels appropriate for certain allied health personnel.

Like the health professions they support, allied health fields have emerged in recent years from a period of expansion, stimulated in some cases by federal subsidy, and now face a period of adjustment

and reorientation. But, unlike the health professions, the allied health occupations have not enjoyed professional autonomy. For that reason, they may not always be able to determine their own future and, as a result, may find it difficult to adapt to those changes which face the health care industry in the years ahead: new reimbursement mechanisms, national health insurance, preventive self-care, cost containment actions by government, holistic health care, health maintenance organizations, etc.

This allied health field is not only an important component of health sciences education, but also has an important role in providing health care services to the citizens of California.

Consequently, the full range of allied health occupations and the educational programs that produce the practitioners in these fields merit attention and support from the State.

FOOTNOTES

- U.S. Department of Health, Education, and Welfare, A Report on Allied Health Personnel, 1979, p. I-3
- 2/ U.S. Department of Health, Education, and Welfare, Health Resources Statistics: Health Manpower and Health Facilities, 1976-77 ed., p. 5.
- 3/ US. H.E.W., Report, 1979, p. I-1.
- 4/ American Medical Association, Allied Health Education Directory, 8th ed., 1979, p. 463.
- 5/ Richard M. Magraw, "Education in the Health Sciences," in Review of Allied Health Education. 2, ed Joseph Hamburg (Lexington, Kentucky: The University Press of Kentucky, 1977), p. 161.
- 6/ Subpart II, Part G, Title VII of The Public Health Service Act, Section 795.
- 7/ National Commission on Allied Health Education, The Future of Allied Health Education (San Francisco. Jossey Bass, 1980), p. 14.
- 8/ American Society of Allied Health Professions, "Allied Health Trends"
- 9/ National Commission, Future of Allied Health Education, p. 2.
- 10/ J. Warren Perry, "The Next Decade: Issues and Challenges," in Review of Allied Health Education: 3, ed. Joseph Hamburg, (Lexington, Kentucky: The University Press of Kentucky, 1977), p. 7.
- 11/ Ibid.
- 12/ Ibid.
- 13/ National Commission, Future of Allied Health Education, pp 19-21.
- 14/ American Medical Association, Allied Health Directory, p. 101.

- 15/ National Commission, Future of Allied Health Education, p. 79.
- 16/ Ibid., pp. 80-81.
- 17/ U.S H.E.W., <u>Report</u>, p. III-1. NB. The National Commission on Allied Health Education would add 3,000 more programs based upon survey nonresponse rates.
- 18/ This committee is a subcommittee of the Academic Planning and Review Board-Health Sciences Committee, a systemwide administrative body, and consists of both faculty and administrators from various campuses. The subcommittee identified the fact that although the University of California has only a few official Degree/Certificate granting programs in allied health, its medical centers do sponsor some independent training programs and provide facilities and faculty for the clinical experience segments of programs offered by the Community Colleges and the State University and Colleges.

PART III

PROMOTION OF HEALTH AND PREVENTION OF DISEASE

In the closing pages of its 1978 Health Sciences Education Plan, the Commission briefly noted the importance of preventive health care and the responsibilities that individuals and governments assume for the promotion of health and the prevention of disease Subsequently, the State Health Plan has also stressed the importance of prevention and self care as means of improving the health of Californians while controlling the spiraling costs of health care.

It is appropriate in this second Commission report to examine what California postsecondary education is doing currently to provide the trained professionals necessary to lead this effort to promote health and prevent disease. This section will also explore briefly how postsecondary institutions can discover and transmit knowledge of healthful living to the citizens of the State.

The State Health Plan describes prevention as a process akin to the traditional functions of "public health." Prevention takes place at three levels: primary, secondary, and tertiary. Primary prevention contains five elements: (1) health education; (2) communicable disease control, including immunization; (3) selected medical services, including family planning, pre-natal care, well-baby care, mental health services, and dental care; (4) nutrition services, particularly for pregnant women, infants, and the elderly; and (5) environmental protection and numerous other public health activities such as sanitarian and radiation protection.

Although these elements stress the role of trained professionals and organizations, the individual is equally important as an agent of prevention in a number of basic areas—diet, exercise; sleep; stress; use of tobacco, alcohol, and drugs; and self-medication. In the final analysis, it is the individual who is the key to health promotion and disease prevention.

Secondary prevention consists of the screening of large groups of people whose illnesses can be avoided or minimized through early treatment—hypertension, vision and hearing defects, venereal disease, etc. Tertiary prevention involves medical care to prevent further complications from the conditions identified through secondary prevention.

The five services identified under the category of primary prevention generally correspond to most people's understanding of what constitutes preventive health care. California already has the educational programs that offer training for these services and health professionals who provide them. Therefore, if the State decided to stress prevention, it would be only a matter of reordering its health care priorities rather than reorganizing and expanding its health sciences education system

Health educators are currently trained by a number of California institutions, are certificated in some cases by the Teacher Preparation and Licensing Commission, and function within both secondary schools and collegiate institutions, providing information about health and hygiene. Communicable disease control is the responsibility of several specialists: physicians trained in public health, biostatisticians functioning as epidemiologists, entomologists serving as vector control officers, and a number of other specialists with comparable educational credentials. Selected medical services are generally in the hands of physicians and nurses with specialized training, or of allied health specialists such as genetic counselors and dental hygienists. Nutrition services are furnished by those trained in a limited number of nutrition programs in the health sciences or in a larger number of programs in home economics. Environmental protection is provided by a corps of specialists educated through a variety of academic programs in industrial hygiene and safety, water and air quality, radiation safety, food and drug quality, etc.

For the most part, professions involved in prevention require advanced education in the sciences. The fields oriented toward the public health approach use the Master of Public Health as the standard educational credential, but many of those who receive this degree have already earned degrees in science or medicine. In a number of environmental health areas, advanced degrees in chemistry or engineering are common.

Graduate medical education programs prepare physicians for specialization in several areas which promote health and prevent disease, for example, prevention, public health, and occupational medicine. In the past, these programs have not been particularly well-developed in California, and the Legislature is now encouraging the University of California to expand its residencies in these areas.

The research function of higher education is also an important element of health promotion and disease prevention. Much of the basic research carried out by faculty, research staff, and students in graduate academic programs in medical schools seeks to develop a better understanding of normal biological processes: metabolism, natural immunity, aging, genetic selection, cell development, etc. Other research strives to identify the pathogens responsible for various kinds of abnormality or illness: micro-organisms, biochemical compounds, viruses, hormones and enzymes, etc. In each case, whether studying the normal or the abnormal, biomedical researchers can provide valuable insights into the maintenance of health.

Another common area of medical research can be called epidemiologic, in that it deals with the incidence, distribution, and control of disease in a population. Originally identified with infectious diseases, this field now includes studies of such conditions as cancer, heart disease, and hypertension. The methodology is pri-

marily a statistical one that attempts to link certain environmental and behavioral parameters to the pathologies they are suspected of causing. In recent years, the work done on the Legionnaire's Disease is the most memorable example of epidemiological research

It is unfortunate that medical research is not always accorded the importance it deserves by some State agencies and among some legislative staff. At times, efforts to encourage greater numbers of primary care health practitioners, a worthwhile goal in itself, seem to be taken at the expense of academic and/or research medicine. Some of the literature of the primary care movement seems to imply that conducting medical research, rather than caring for patients, is a less than worthy goal for promising students. In fact, the 1979 Health Manpower Plan suggests limiting the number of medical students who are allowed to go into academic and research medicine to five percent of the total.

In the 575 pages of the State Health Plan, there are only a few paragraphs devoted to research. Included is a call for the establishment of a State epidemiological research unit that would conduct research in the "determinants of health," evaluate other research, and advise State agencies on effective intervention strategies and resource allocations. No other type of research is mentioned. Perhaps, like much of the basic and applied research of universities and laboratories in other fields, medical research has failed to "sell" its product to the public and to government. This is unfortunate; research has so much to offer in the prevention of disease—as witnessed by the great medical breakthrough of our time, the near—eradication of polio through the Salk vaccines, a product of biomedical research.

Research findings in matters of health are generally reported in scientific and professional journals in what amounts to a peer-review process, with findings that survive the rigid scrutiny of colleagues, then becoming part of the "literature" of the field. Because of the enormous public concern with matters of health, the mass media monitor some of the leading medical journals for items of interest to the lay-audience. In recent years, it has become fairly common to see or hear The New England Journal of Medicine or the Journal of the American Medical Association quoted in stories in print or in the electronic media.

While such an approach may produce some technical inaccuracies and perhaps an overstatement of the benefits of a new medical concept, it is a fairly effective means of assuring that the general public is aware of new developments in health. Since the consumer needs to know not only how to manage his or her own health, but also how to use the formal health care system—including knowing how to stay out of it as long as possible, and how and where to enter it when necessary, this process linking research and prevention is a vital part of the educational system.

APPENDIX

Recommendations of the Graduate Medical Education National Advisory Committee*

Source: Chronicle of Higher Education; October 6, 1980.

WASHINGTON

Following is the text of recommendations in the summary report of the federal government's Graduate Medical Education National Advisory Committee The committee's summary condenses 107 recommendations included in its complete six-volume report to Secretary of Health and Human Services Patricia R Harris

Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 per cent by 1984 relative to the 1978-79 enrollment or 17 per cent relative to the 1980-81 entering class

Supportive recommendations

- A No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-81
- B No increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981 should occur
- C The current Health Professions Law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers to allow them to ignore the law's requirement to increase enrollment This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants' Program
- D The current Health Professions Law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at the level of the preceding school year. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants' Program.
- The number of graduates of foreign medical schools entering the U S yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to U S medical schools

Supportive recommendations

- A All federal and state assistance given through loans and scholarships to U S medical students initiating study abroad after the 1980-81 academic year should be terminated
- B The current efforts in the private sector to develop and implement a uniform qualifying examination for U S citizens and aliens graduating from medical schools other than those approved by the LCME (Liaison Committee for Medical Education) as a condition for entry into L c G M E (Liaison Committee for Graduate Medical Examination) approved graduate training programs should be supported Such an examination must assure a standard of quality equivalent to the standard applied to graduates of Liaison Committee on Medical Education accredited medical schools These U.S. citizens and aliens must be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination. The Educational Commission for Foreign Medical Graduates (ECFMG) exammation should not be used as the basis for measurement of the competence of [American graduates of foreign medical schools) or alien physicians
- C Alten physicians, who enter the United States as spouses of U S citizens, should be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination prior to entry into residency training
- D The ability to read, write, and speak English should remain a requirement for graduate medical education programs for all alien physicians.
- E The Federation of State Medical Boards should recommend and the states should require that all applicants successfully complete at least one year of a G.M E (graduate medical-education) program that has been approved by the L C G.M E and successfully pass an examination prior to obtaining unrestricted licensure. The examination should assure a standard of quality in the ability to take medical histories, to do physical examinations, to carry out procedures, and to develop diagnostic and treatment plans for patients. The standard of quality should be equivalent to graduates of United States medical schools

- F The states should severely restrict the number of individuals with limited licenses engaged in the practice of medicine. This restriction applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision.
- G The "fifth Pathway 'for entrance to approved programs of graduate medical education should be eliminated
- H The transfer of U S citizens enrolled in foreign schools into advanced standing in U S medical schools should be eliminated
- O The need to train nonphysician health care providers at current levels should be studied in the perspective of the projected oversupply of physicians
- To correct shortages or surpluses in a manner not disruptive to the G M E system, no specialty or subspecialty should be expected to increase or decrease the number of first-year training programs more than 20 per cent by 1986 compared to the 1979 figure
- 5 In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980's should be strongly encouraged to enter those specialties where a shortage of physicians is expected or to enter training and practice in general pediatrics, general internal medicine, and family practice
- 6 Extensive research on the requirements for N P's [nurse practitioners], P A's [physician s assistants.] nurse-midwives, and other nonphysician providers should be undertaken as soon as possible Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complementary and substitute services.
- Until the studies in Recommendation 6 have been completed, the number of PA's, NP's, and NMW's [nurse-midwives] in training for child medical care, adult medical care, and obstetrical/gynecological care should remain stable at their

present numbers. Delegation levels recommended by GMFNAC for 1990 are in obstetrics/gynecology 197,000 of the normal uncomplicated deliveries (5 per cent of all deliveries). 7 | million maternity-related visits (20 per cent of the obstetrical caseload). and 7.5 million gynecological visits (19 per cent of the gynecological caseload), in child care not more than 46 million ambulatory visits (16 per cent of the child ambulatory caseload, and in adult medical care not more than 128 million ambulatory visits (12 per cent of the adult medical ambulatory caseload)

All incentives for increasing the class size or the number of optometric or podiatric schools should cease until the studies in Recommendation 6 have been completed and evaluated

State laws and regulations should not impose requirements for physician supervision of N P 's and P A 's, beyond those needed to assure quality of care

Supportive recommendations:

- A State laws and regulations should be altered as necessary so that a PA or NP working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable
- B The states should provide P A.'s, N P's, and nurse-midwives with limited power of prescription, taking necessary precaution to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision
- C At a minimum, P A 's, N P 's, and nurse-midwives should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition
- D States, particularly those with underserved rural areas, should evaluate whether the laws and regulations pertaining to nonphysician practice discourage nonphysician location in these areas
- The requirements of third party payors for physician supervision should be consistent with the laws and regulations governing non-physician practice in the state

I Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services by N P's, P A's, and nurse-midwives in those states where they are legally entitled to provide these services Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician

12 N P's, PA's, and nurse-midwives should be engible for all federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program

Graduate medical education should be constructed to give residents experience in working with PA's, NPs, and nurse-midwives to insure that these physicians will be prepared to utilize nonphysician services

14 GMENAC recommends that the basic unit for medical manpower planning should be a small geographic area within which most of the population receives a specified medical service. These functional medical service areas, service by service, are recommended as the geographic units for assessing the adequacy of manpower supply

15 OMENAC encourages the support of efforts within the profession to assess the outcomes of common medical and surgical practices exhibiting high variation across communities. Accomplishing this step would help to establish long-range requirements for physician services in the United States.

Variations between communities in the utilization of specific medical services should be continuously documented and analyzed. The effect of differing financing and organizational arrangements for the delivery of medical care services should be evaluated.

Supportive recommendations

A Utilization rate experiences, relative to the norms of other physicians practicing in the immediate area, the region, or the nation, should be made available to physicians B Future health manpower planning groups should compare manpower estimates, whether derived from "need" based, "demand" based, or "requirements" based models, against empirical estimates selected from areas in the United States exhibiting high and low utilization patterns

17 GMENAC recommends that health manpower shortage area be defined by a minimum service specific physician to population ratio and a maximum travel time to service for child care, adult medical care, obstetnical services, general surgical services, and emergency medical services.

Supportive recommendations

A The minimum acceptable physician to population ratio for any area in the U S should be 50 per cent of the requirements estimated by GMENAC for each type of health service in the nation as a whole

B Maximum travel times to service for 95 per cent of the population within a geographic area should be 30 minutes for child care, adult medical care and emergency medical service, 45 minutes for obstetrical care, and 90 minutes for general surgical services

Alternative data systems for monitoring the geographic distribution of physicians should be developed and evaluated

19 Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches. (1) urban and rural preceptorships should be continued and expanded by those schools having an interest, (2) governmental loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving geographic distribution, (3) loan forgaveness programs modeled after those which have been successful should be used. and (4) the National Health Service Corps and its scholarship program should be supported

2() The medical profession in making decisions as to residency training programs should consider the aggregate number of programs, their size, and the geographic distribution of their graduates, in addition to the quality of the program, in light of national and regional needs

2 I Family practice residency training programs should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas

A similar rationale underlies support needed for resident experiences in underserved areas and for certain nonphysician provider training programs

- Area-wide programs of decentralized medical education and service such as wami (Washington, Alaska, Montana, and Idaho), wiche (Western Interstate Commission for Higher Education), and some a HeC's (Area Health Education Centers) should be evaluated for replicability. Such programs have been effective in placement of physicians in sparsely populated areas
- 23 More research and evaluation should be conducted on factors relating to the geographic distribution of physicians
- Medical education in the medical schools and in the early phase of graduate medical education in the teaching hospitals should provide a broad-based clinical experience with emphasis on the generalist clinical fields. A portion of graduate medical training should occur in other than tertiary care medical centers.
- 25 A more vigorous and imaginative emphasis should be placed on ambulatory care training expenences

Supportive recommendations:

- A. The out-patient services of the academic medical centers should be upgraded through special project grants
- B Educational innovation in outpatient settings should be fostered by providing financial support
- c Faculty should be encouraged and supported to develop careers focused on ambulatory medicine through a career development award mechanism
- 26 Greater diversity among the medical students should be ac-

complished by promoting more flexibility in the requirements for admission, by broadening the characteristics of the applicant pool with respect to socio-economic status, age, sex, and race, by providing loans and scholarships to help achieve the goals; and by emphasizing, as role models, women and under-represented minority faculty members

- 27 Information about physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to medical schools, administrators, faculty, and medical students, residents, fellows, and spouses
- 28 Capitation payments to medical schools for the sole purpose of increasing class size or for influencing specialty choice should be discontinued in view of the impending surplus of physicians.
- 29 Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued in order to continue and to increase the emphasis on primary care services and ambulatory care

Supportive recommendations

- A Family practice programs, at least for the near term, should be given special attention in view of the difficulty in financing training programs from ambulatory care revenues
- B. Specialities in short supply should be considered for special project grants
- Ambulatory care training should be promoted further by the provision of grants for renovation and construction of facilities, for the support of training programs in ambulatory sites, and for student preceptorships and residency experiences in out-of-hospital care
- 31 The medical profession, having the major responsibility for correcting physician oversupply, should insure the quality of all graduate medical education programs and full funding of these programs through reimbursement should be given only to accredited programs when mechanisms are in place

- 32 Calculations of the true costs of graduate medical education should include the compensation for residents and teaching personnel and all of the ancillary and indirect costs, should distinguish between the cost of education and the cost of patient care by a uniform recognized reporting system Costs should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided to the extent that such costs are not financed by tuition, grants; or other sources of revenue
- 33 The health professions should assume a major responsibility for cost containment in new program development, in accreditation and certification, and in the provision of health services.
- Public and private reimbursement policies should be adjusted to emphasize ambulatory care services and training, encourage practice in underserved areas, explore the concept of shared risk among physicians, and pay professional fees to teaching physicians where their services have been identifiably discrete and necessary
- 35 Continuous monitoring and new financial programs should be supported. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts have been performed.
- 36 Additional research should be accomplished on a broad array of topics related to financial considerations
- 37 Special project grants for states on a cost sharing basis should be considered to influence the geographic distribution of physicians within the states. The development of incentives for practice in underserved areas is one program to be considered.
- Of The development of future Of medical faculty, administrators, and researchers should be assured by provision of adequate financial support for their training

A successor to the Graduate Medical Education National Advisory Committee should be established by statute This successor should be an advisory body without regulatory functions

4() In addition to the continuous monitoring, the supply projections, requirements estimates, and recommendations of GMENAC in their entirety must be reevaluated and modified at least every five years to take account of changes in data, assumptions, and priorities occurring over time